

Wilson Orthopaedics, P.L.L.C.

Arnold B. Wilson, M.D., F.A.A.O.S.

75 East Gunhill Road

Bronx, New York 10467

(718) 798-1000 * (718) 798-6900 * (718) 798-5522

www.wilsonorthopedics.com



Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone #: (_____) _____ - _____ **Cell Phone #:** (_____) _____ - _____

Social Security #: _____ **DOB:** _____

Employer Info: _____

Emergency Contact Person: _____

Phone #: (_____) _____ - _____

Attorney Name: _____

Attorney Phone #: (_____) _____ - _____

Adjuster Name _____

Adjuster Phone #: (_____) _____ - _____

Address to Submit Claims: _____

Describe Injury: _____

Referred by: _____

Patients Signature: _____ **Date:** _____

Wilson Orthopaedics, PLLC.

Arnold B. Wilson, M.D., F.A.A.O.S.

Orthopaedics and Reconstructive Surgery

Sports Medicine

75 East Gun Hill Road
Bronx, New York 10467

Release of Information and Payment Authorization

I hereby authorize my physician and anyone that he/she appoints to furnish any and all of my medical records and history, services rendered of treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted to the insurance carrier.

I also authorize the insurance carrier to disclose to a hospital, health care service plan any medical information obtained if such disclosure is necessary to allow processing of a claim.

If my coverage is under a group contract held by an employer, an association, trust fund, union of similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

This authorization shall become effective immediately upon execution and shall remain in effect for the duration of any claim or term of severance with the insurance carrier including a reasonable time thereafter, until it's final consummation. This authorization shall be binding upon my dependents, heirs, executors, administrators and me.

I also request that payment of authorized Medicare benefits be made on my behalf to WILSON ORTHOPAEDICS, PLLC., for services furnished to me by my provider. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Patient Signature or Authorized Signature

Date
