Dr. Daniel Cameron and Associates

Daniel J. Cameron, M.D., M.P.H., P.C.

657 Main Street, Mt. Kisco, NY 10549

Phone: 914-666-4665 Fax: 914-666-6271

DATE: _____

PATIENT INFORMATION						
Patient's Last Name	Patient's First Name					Home Phone No.
Street Address	City		State		Zip Code	Social Security No.
Occupation (Indicate if student)	M	F	Date of Birth	Age	Marital Status	Spouse's Name (If applicable)
Patient's Employer/School Name	Cell Phone No.					Work Phone No.
Employer Address	City			State		Zip Code

OTHER INFORMATION			
Emergency Contact	Relationship		Phone No.
Referred By:	County you live in		How long did it take you to get here?

INSURANCE INFORMATION			
Primary Insurance Company	Name of Policy Holder (If not self)		
Primary Insurance ID #	Group #	Policy Holder's DOB	Co-pay Amount
Social Security # of Policy Holder	Relation to Policy Holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

OTHER INSURANCE INFORMATION			
Secondary Insurance Company	Name of Policy Holder (If not self)		
Secondary Insurance ID #	Group #	Policy Holder's DOB	Co – pay amount
Social Security # of Policy Holder	Relation to policy holder	Is your primary insurance through an employer? Yes / No Employer's Name:	

I authorized the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I certify that the information I have reported above is truthful to the best of my knowledge. **I understand that if the insurance information I have provided is incorrect or not in effect for the date of service, that I will be responsible for all charges incurred.** I understand that I am responsible for the terms and conditions of my individual insurance plan. Due to the vast number of different insurance policies, I realize that Dr. Daniel Cameron and Associates/FMA personnel are not responsible for informing me which test and procedures are covered. I herby give consent to medical examination and treatment for the above patient.

_____ _____ _____

Signature Of Patient Responsible Party (***MUST BE OVER 18***) Relation (Example: Self, Spouse, Parent) Date:

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PATIENT INFORMATION FORM

Name: (Last) _____ (First) _____ (MI) _____
Name you prefer to be called: _____
Address: _____City:_____ State: _____ Zip: _____
Cellular#: _____ Home Phone#: _____
Email Address: _____ SS# _____
Birth Date: _____ Age: _____ Gender: □ M / □ F

NO REFUND POLICY

By signing this No Refund Policy, I am agreeing that any service(s) I received(s) at Daniel Cameron M.D., M.P.H, P.C. & Associates is final. I understand any and all services(s) received will not be refunded or issued a credit.

I also understand that if I decide to cancel or postpone any service(s), I will forfeit all monies paid; including any deposits and/or payments I have already paid. I also understand that if I decided not to notify Daniel Cameron M.D., M.P.H, P.C. & Associates about postponing any services, I will be responsible for paying a fee.

By signing this No Refund Policy, I understand and agree to all terms and conditions of here said policy. All of my questions have been answered concerning the No Refund Policy.

_____ _____
Patient/Client Signature Date

_____ _____
Parent if patient is a minor Date

_____ _____
Witness Date

Daniel J. Cameron, MD, MPH, PC

657 East Main Street, Suite 2, Mount Kisco, New York
Tel: 914-666-4665 Fax: 914-666-6271

Credit Card Authorization Form
Please fill out and complete this authorization form and return it to us.
All information will remain confidential.

Cardholder name: _____

Billing address: _____

Credit card type: ___ Visa ____ Master card _____ Discover ____ AmEx ____

Credit card number: _____

Expiration number: _____

Card identification number (last 3 digits locate on the back of the credit card.

Amount to charge $200.00 (USD). This non-refundable will be deducted from the new visit fee.

I understand that I am being charged a deposit for my new patient appointment and authorize Daniel Cameron, MD to charge $200.00 to my credit card listed above.

Cardholder – Print Name, sign and date below.

Print name: _____

Signature: _____

Date: _____

Once your credit card authorization form is completed and signed, please return it to:

1. Dr. Cameron using PDFFiller.
2. Or Email: info@DanielCameronMD.com
3. Or Fax: 914-666-6271