Morgan Road FamilyCare

Bruce Silverstein, MD
Jaclyn Snyder, RPA-C
7445 Morgan Rd, Liverpool, NY 13090

Patient Registration Form

Please Print

Date: ___________

Name: _______________________________________ DOB: ____/_____/_____ Sex: ___M ____F
Address: _________________________________ City: ________________ Zip: ______________
Phone: ___________________ Cell: _____________________ Work: _______________________
Social Security Number: ______________________________
Pharmacy Name & Street Address: ____
Pharmacy Phone: ____________________________________

Employer: ________________________________ Occupation: _____________________________
Emergency Contact Name & Number: ____
Language Preference: _____________ Race: _____________
Ethnicity: Non-Hispanic Origin _____ Hispanic Origin ____ Decline To Specify ____

Insurance

Primary Insurance Company: ________________ ID# _____________________________________
Subscriber Name (Name on card):_____________________ DOB: _____/______/_____________
Relation to Patient: ____
Subscriber Address: ____

Secondary Insurance Company: ________________ ID# __________________________________
Subscriber Name (Name on card):_____________________ DOB: _____/______/_____________
Relation to Patient: ____
Subscriber Address: ____

** I consent to have the Practice use and disclose my protected health information for payment, treatment, and health care operation purposes, and for such other purposes that are permitted under the HIPPA or other federal or state law without my written authorization. I authorize the payment of medical benefits to the above stated physician or supplier for services rendered

Signature: ____ Date: ________________________

Morgan Road FamilyCare
Bruce Silverstein, MD
Jaclyn Snyder RPA-C
7445 Morgan Road,
Liverpool, NY 13090
(315) 420-5056

No Show, Late Cancellation Fee and MRFC Office Policy

When a patient misses an appointment without providing advance notice other patients are prevented from receiving care. We reserve the right to charge for these occurrences.

Due to high patient demand and appointment availability we have instituted a fee of $50.00 for no show and late cancellations for *all* appointments. Therefore, kindly give **24 hour advance notice** to cancel/reschedule appointments to avoid these fees and possible discharge from the practice.

By signing below, I acknowledge that I have read and understand the No Show and Late Cancellation Fee policy.

______________________________ ______________

Print Patient Name **Date of Birth**

______________________________ ______________

SIGNATURE of Patient or Guardian Date

☐ I have read, understand and agree to the terms governing the Morgan Road FamilyCare Office policy.

IF YOU WISH TO RECEIVE EMAIL REMINDERS PLEASE **PRINT** EMAIL BELOW

______________________________________@______________________