

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: _____

Bruce Silverstein, MD
Morgan Road Family Care
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.

*If a **NEW PATIENT APPOINTMENT** is missed another appointment will not be offered until this fee is paid.

Therefore, kindly give **24 hour advance notice** to cancel/reschedule appointments to avoid this fee.

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

Print Name

Date of Birth

Patient Signature

Date