

**David S. Prince, M.D.**  
**Clarke U. Piatt, M.D.**  
**Joseph M. Abboud, M.D.**  
**Catherine A. Riley, M.D.**  
**Michael E. Post, D.O.**  
**Melinda L. Darnell, M.D.**

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Pulmonary, Critical Care and Sleep Medicine  
Bryn Mawr Medical Specialists Association  
**Bryn Mawr Medical Arts Pavilion**  
**825 Old Lancaster Road, Suite 420**  
**Bryn Mawr, PA 19010**  
**610-527-4896**

Please complete the enclosed registration and medical history forms, and bring them with you on the day of your appointment.

**If your insurance company requires a referral for your office visit, please contact your primary doctor.**

If you had radiology imaging done outside of the Main Line Health system or hospitals, please remember to bring those films and reports with you to your initial visit.

It is recommended that you bring your prescription formulary with you to this visit to ensure medications ordered are covered and affordable.

**Please provide a minimum of 24 hours' notice if your appointment needs to be rescheduled for any reason. We reserve the right to charge \$75.00 for missed appointments or appointments cancelled with less than 24 hours' notice.**

We look forward to meeting with you!

# We would like to invite you to BMMSA's Patient Portal

\*Please note that our portal is separate for My Chart (Main Line Health's portal)

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

\_\_\_\_\_ I would like to be signed up on the portal. My email address is

\_\_\_\_\_

\_\_\_\_\_ I decline

\_\_\_\_\_ I am already signed up

## FOR FUTURE APPOINTMENTS, LET US KNOW YOUR PREFERENCE.

Please contact me by:

\_\_\_\_\_ Text message to cell # \_\_\_\_\_

\_\_\_\_\_ Phone call to landline or cell \_\_\_\_\_  
(Please circle one)

\_\_\_\_\_ Both

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NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

REFERRING PHYSICIAN NAME AND ADDRESS:

\_\_\_\_\_

LIST ANY OTHER MEDICAL SPECIALISTS YOU REGULARLY SEE:

\_\_\_\_\_

LIST THE MAIN PROBLEM, SYMPTOMS OR REASONS YOU ARE COMING TO SEE THE DOCTOR:

\_\_\_\_\_  
\_\_\_\_\_

LIST ALL DRUG ALLERGIES AND SENSITIVITIES:

\_\_\_\_\_  
\_\_\_\_\_

LIST ALL CURRENT MEDICATIONS, STRENGTH AND FREQUENCY (include inhalers)

_____	_____
_____	_____
_____	_____
_____	_____

LIST PAST/CURRENT MEDICAL CONDITIONS:

_____	_____
_____	_____
_____	_____
_____	_____

LIST PRIOR SURGERIES: (Also list planned surgeries)

_____	_____
_____	_____

DO YOU HAVE PROBLEMS WITH COUGH?

YES NO

If yes, describe \_\_\_\_\_

ARE YOU SHORT OF BREATH:

YES NO

If yes, describe \_\_\_\_\_

ARE YOU SHORT OF BREATH AT NIGHT?

YES NO

If yes, describe \_\_\_\_\_

DO YOU EVER WHEEZE?

YES NO

**WHAT IS YOUR OCCUPATION?**

What have you done in the past?

---

**LIST POTENTIAL WORK OR ENVIRONMENTAL EXPOSURES:**

---

**HAVE YOU EVER SMOKED?**

YES NO

Are you currently smoking?

YES NO

Have you tried to quit smoking before?

YES NO

How many years total have you smoked? \_\_\_\_\_ How many packs per day: \_\_\_\_\_

If you stopped, how many years ago did you quit? \_\_\_\_\_

Have you used cigars or chewing tobacco? Describe: \_\_\_\_\_

**DO YOU DRINK ALCOHOL?**

YES NO

If yes, circle one: every day once or twice a week rarely/several times a month

**WHO LIVES WITH YOU AT HOME?**

---

**TRAVEL HISTORY:** List any significant travel within or outside of the United States in the last 5 years

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**LIST ALL PETS AND ANIMAL EXPOSURES/SENSITIVITIES:**

---

**FAMILY HISTORY:** (Circle all that apply)

Lung diseases	Asthma	Cancer	Sleep apnea
Deep vein clot (DVT)	Pulmonary emboli	Cystic Fibrosis	Stroke
Heart attack	Congestive Heart Failure	Diabetes	Depression
Hypertension	Other (please list): _____		

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Mother's age alive: \_\_\_\_\_ deceased/age: \_\_\_\_\_ cause: \_\_\_\_\_  
Father's age alive: \_\_\_\_\_ deceased/age: \_\_\_\_\_ cause: \_\_\_\_\_

**DO YOU SNORE?** YES NO

**ARE YOU SLEEPY DURING THE DAY?** YES NO

**DO YOU HAVE INSOMNIA?** YES NO

If yes, describe: \_\_\_\_\_

**DO YOU HAVE LEG DISCOMFORT ASSOCIATED WITH SLEEP?** YES NO

**DO YOU KICK IN YOUR SLEEP?** YES NO

**LIST BEDTIME** \_\_\_\_\_ **LIST WAKE TIME** \_\_\_\_\_

**TIME TO SLEEP ONSET** \_\_\_\_\_ **Number of waking episodes at night** \_\_\_\_\_

**DESCRIBE CAFFEINE USE** \_\_\_\_\_

---

**DID YOU EVER HAVE PNEUMONIA VACCINE?**

**YES**

**NO**

Prevnar: \_\_\_\_\_ Date \_\_\_\_\_ Pneumovax \_\_\_\_\_ Date \_\_\_\_\_

**DO YOU RECEIVE ANNUAL FLU OR INFLUENZA VACCINATION?**

**YES**

**NO**

**REVIEW OF SYSTEMS:**

Circle all that apply:

**GENERAL**

- Weight loss
- Weight gain
- Fever
- Chills
- Night sweats
- Feeling Tired (fatigue)
- Other \_\_\_\_\_

**SLEEP**

- Insomnia
- Snoring
- Gasping for breath at night
- Involuntary movements during sleep

**GASTROINTESTINAL**

- Nausea
- Vomiting
- Heartburn or reflux
- Diarrhea
- Constipation
- Swallowing difficulty
- Choking on food
- Stomach pain
- Blood in stool

**HEAD AND NECK**

- Sinusitis
- Nasal congestion
- Seasonal Allergies
- Nosebleeds
- Cough
- Vision difficulties
- Loss of hearing
- Ringing in ears
- Hoarseness

**RESPIRATORY**

- Shortness of breath
- Shortness of breath when flat in bed
- Coughing up blood

**CARDIAC**

- Palpitations
- Chest Pain
- Swelling of legs or ankles
- Angina

**BONE and JOINTS**

- Joint pain
- Muscle pain
- Back pain

**NEUROLOGIC**

- Numbness
- Weakness
- Headache
- Tremor
- Poor memory

**SKIN**

- Rash
- Wounds
- Bruise easily

**MEN**

- Incontinence (loss of control of urine)
- Impotence
- Urinary difficulty
- Frequent nighttime urination

**WOMEN**

- Incontinence (loss of control of urine)
- Menopause
- Irregular menstrual cycle

FOR OFFICE USE ONLY

SYSTEMS REVIEWED IN FULL AND NO OTHER SIGNIFICANT FINDINGS NOTED

\_\_\_\_\_  
ATTENDING

\_\_\_\_\_  
DATE

## PAST MEDICAL HISTORY

### PULMONARY

Abnormal TB Test  
Asthma  
COPD  
Cough Emphysema  
Lung Mass  
Pneumonia  
Pulmonary Embolism  
Sarcoidosis  
Sleep Apnea  
Tuberculosis

### CARDIOVASCULAR

Atrial Fibrillation  
Anemia  
Coronary Artery Disease  
Cardiomyopathy  
Congestive Heart Failure  
DVT  
Hypertension  
Hyperlipidemia  
Peripheral Vascular Disease  
Syncope  
Transient Ischemic Attack

### HEAD

Cataract  
Glaucoma  
Sinusitis  
Visual Disturbances

### MUSCULOSKELETAL

Connective Tissue Dx  
Osteoarthritis  
Osteoporosis  
Systemic Lupus  
Rheumatoid Arthritis

### ENDOCRINE

Hypothyroidism  
Hyperthyroidism  
Diabetes 1  
Diabetes 2

### GASTROINTESTINAL

Chronic Liver Disease  
Colitis  
Crohn's Disease  
Diverticulosis  
Esophageal Reflux  
Peptic Ulcer

### GENITOURINARY

Benign Prostatic Hypertrophy  
Erectile Disorder  
Urinary Tract Infection  
Renal Disorder

### NEUROLOGICAL

Anxiety Disorder  
Depression  
Headache  
Migraine Headache  
Seizure Disorder

## CANCER

Bladder  
Bone  
Brain  
Breast  
Cervical  
Esophageal  
Gastric  
Hodgkin's  
Non-Hodgkin's Lymphoma  
Kidney  
Other

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Laryngeal  
Leukemia  
Liver  
Lung  
Prostate  
Rectal  
Skin  
Testicular  
Thyroid  
Uterine

## SURGICAL HISTORY

### ORTHOPEDIC

Shoulder Surgery  
Wrist Surgery  
Hand Surgery  
Hip Surgery  
Knee Surgery

### HEAD & NECK

Tonsillectomy  
Throat Surgery  
Neck Surgery  
Cataract Surgery  
Sinus Surgery  
Thyroid Surgery

### LUNG

Bronchoscopy  
Lung Biopsy  
Lobectomy  
Lung Surgery

### GYNECOLOGICAL

Breast Biopsy  
Mastectomy  
C-Section  
Hysterectomy

### CARDIOVASCULAR

Thoracic Aneurysm  
Abdominal Aortic Aneurysm  
Heart Valve Replacement  
PTCA-Percutaneous Transluminal  
Coronary Angiograph  
Facial Surgery  
CABG-Coronary Artery Bypass  
Carotid Endarterectomy  
Catheterization

### GI/GU

Appendectomy  
Cholecystectomy (Gallbladder)  
Prostatectomy  
Gastrointestinal Surgery  
Bariatric Surgery

Bryn Mawr Medical Specialists Association			2026 Patient Intake Form		
Visit Date:		Provider:			
Last Name:		First Name:		DOB:	
Last PCP Visit:		PCP Name:		PCP Phone Number:	
<b>Tobacco Status – All Patients</b>					
Are you a current tobacco user? <span style="float: right;">o Yes o No</span>					
<b>Colorectal Cancer Screening: Patients aged 45 to 75 years - Choose ONE</b>					
Do you have a history of a total colectomy or colorectal cancer?					o Yes o No
Have you had a Fecal occult blood test (FOBT) this year?			Date: _____	o Yes o No	
Have you had a Flexible sigmoidoscopy this year or in the last five years?			Date: _____	o Yes o No	
Have you had a Colonoscopy in the past 10 years?			Date: _____	o Yes o No	
Have you had a Cologuard or FIT-DNA this year or in the past three years?			Date: _____	o Yes o No	
<b>Female Patients aged 50 – 74: Breast CA Screening</b>					
Have you had a bilateral mastectomy?					o Yes o No
Have you had a Mammograms during the last 27 months? (10/1/2024-12/31/2026)			Date: _____	o Yes o No	
<b>Depression Screening part 1 – All patients (If you answer yes to any of these questions, please complete part 2)</b>					
Depression: Little interest or pleasure in doing things?					o Yes o No
Depression: Feeling down, depressed, or hopeless?					o Yes o No
<b>Depression Screening part 2 – All patients pt (If you answered yes to any questions in part 1, please answer the questions below)</b>					
Little interest or pleasure in doing things?		o Not at all o Several Days o More than half the days o Every Day			
Feeling down, depressed, or hopeless?		o Not at all o Several Days o More than half the days o Every Day			
Trouble falling or staying asleep or sleeping too much?		o Not at all o Several Days o More than half the days o Every Day			
Feeling tired or having little energy?		o Not at all o Several Days o More than half the days o Every Day			
Poor appetite or overeating?		o Not at all o Several Days o More than half the days o Every Day			
Feeling bad about yourself or that you are a failure or have let yourself or family down?		o Not at all o Several Days o More than half the days o Every Day			
Trouble concentrating on things such as reading newspaper or watching television?		o Not at all o Several Days o More than half the days o Every Day			
Moving or speaking slowly or being fidgety or restless		o Not at all o Several Days o More than half the days o Every Day			
Wishing to be dead or hurting yourself?		o Not at all o Several Days o More than half the days o Every Day			
Activities of daily living due to the depression symptoms are:		o Not difficult at all o Somewhat difficult o Very difficult o Extremely difficult			
<b>Staff Use Only: Diabetes HgBA1C poor Control, Goal &lt; 9%</b> <span style="float: right;">o HgbA1C level (must be performed in 2026): _____</span>					
<b>ENTER IN LABS IN EMR</b>					
<b>HTN All patients diagnosed with hypertension:</b>			Blood Pressure: _____ Enter in EMR		
<b>Goal BP &lt; 140/90</b>					

# ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & CONSENT TO USE HEALTH INFORMATION

## Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes Bryn Mawr Medical Specialists Association to use health information about you for treatment, payment, and health care operations purposes only.

**Notice of Privacy Practices (last revised 3/2026):** Bryn Mawr Medical Specialists Association has a Notice of Privacy Practices which describes how we may use your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. Please review our current notice prior to signing this acknowledgement and consent.

<https://bmmsa.com/wp-content/themes/bmmsa/assets/pdf/bmmsa-hippa-notice-of-privacy-practices.pdf>

If you would like to receive a paper copy of the Privacy Notice, please request one at the time of your appointment.

Amendments: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Mail: Bryn Mawr Medical Specialists Association  
825 Old Lancaster Road, Suite 320  
Bryn Mawr, PA 19010  
Attention: Salvatore Filippello

Phone: (610) 527-3800, extension 4177

### Acknowledgement & Consent

I have received the notice of Privacy Practices for Bryn Mawr Medical Specialists Association. Bryn Mawr Medical Specialist Association is authorized to use health information regarding \_\_\_\_\_  
(**Print Name**) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

\_\_\_\_\_  
Signature of Patient or Representative                      Date of Birth                      Date                      Account #

Relationship to Patient (if applicable): \_\_\_\_\_

### Release of Covered Information

Please **CIRCLE** your preferred phone number

Home: \_\_\_\_\_ Office may leave **message with detailed information.**

Mobile: \_\_\_\_\_ Office may leave **message with callback number/name only.**

Email Address: \_\_\_\_\_

I give permission to disclose personal health information to the following person(s):

Name	Relationship (spouse, parents, adult children, siblings, personal representative, etc.)	Phone Number

CARDIOLOGY

John P. Fisher, M.D.  
Sean C. Curran, M.D.  
Sheetal Chandhok, M.D.  
Tarun Mathur, M.D.  
Laura S. Immordino, M.D.  
Manju B. Jayanna, M.D.  
(610) 525-1202  
Glenn R. Harper, M.D.  
John C. Steers, Jr., M.D.  
Lawrence S. Mendelson, M.D.  
Howard B. Kramer, M.D.  
Sarang S. Mangalmurti, M.D.  
(610) 527-1165  
Jason T. Bradley, M.D.  
Jeffrey A. Wuhl, M.D.  
(484) 380-2808

BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

825 OLD LANCASTER ROAD  
SUITE 320  
BRYN MAWR, PENNSYLVANIA 19010

**Financial Policy**

**We would like to take this opportunity to welcome you to our offices and assure you that we will do our utmost to provide you with the best possible care.**

Patients with Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier. It is your responsibility to read and understand your insurance agreement; certain services may or may not be covered, depending on your individual policy. **Please provide current insurance information to the office, including any changes in coverage.** If your insurance requires a form, please provide one to the office. We will bill your insurance carrier as a courtesy to you. **However, you are ultimately responsible for the payment of the bill.**

Portions of the bill may not be paid by the insurance company, and are to be paid by the patient. For example, a co-payment may be required by you as per your insurance agreement. If you are having treatment over a period of time, we appreciate payment during the course of treatment. Our Business Office will gladly assist you in arranging a payment plan. If you are unable or unwilling to accept responsibility for your account balance, please be advised that your account may be forwarded to a collection agency, which will adversely affect your credit.

If you have a **High Deductible Health Plan (HDHP)**, please notify the office prior to your visit. If you have not met your deductible, we will bill you directly for any balance due. Please note, the office may request payment up front.

If you are covered through an **out-of-state insurance plan**, it is your responsibility to contact your carrier and determine if our physicians participate with your plan. Please note that these types of plans typically carry high out-of-pocket expenses.

Patients without Insurance Coverage

Patients without insurance coverage are requested to pay for services as rendered. We accept MasterCard and Visa payments.

**I have read and understand the Financial Policy of Bryn Mawr Medical Specialists Association.**

X \_\_\_\_\_  
**Signature of Patient or Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Account Number**

**Revised: January 30, 2026**

DERMATOLOGY

Rochelle R. Weiss, M.D.  
Daniel B. Roling, M.D.  
Matthew E. Halpern, M.D.  
Caroline M. MacFarlane, M.D.  
Michael D. Gober, M.D.  
(610) 642-1090

ENDOCRINOLOGY

Cheryl A. Koch, M.D.  
Vanita P. Treat, M.D.  
Denise Joffe, M.D.  
(610) 527-1604

GASTROENTEROLOGY

Jack A. Collazzo, M.D.  
Tom T. Nguyen, M.D.  
Thomas J. McKenna, M.D.  
Michelle C. Springer, D.O.  
Jonathan I. Gotfried, M.D.  
Nikhita M. Dharbhamulla, M.D.  
William P. Haberstroh, D.O.  
(610) 525-9570

HEMATOLOGY-ONCOLOGY

John G. Devlin, M.D.  
Sameer Gupta, M.D., MPH  
Molly S. Stumacher, M.D.  
Eric B. Fox, D.O.  
(610) 525-4511

INFECTIOUS DISEASE

Bartholomew R. Bono, M.D.  
Luciano Kapelusznik, M.D.  
Young S. Kim, M.D.  
Adrian T. Estepa, M.D.  
(610) 527-8118

NEUROLOGY

Christopher J. Reid, M.D.  
George J. Hart, M.D.  
Pragati Shukla, M.D.  
Laurence D. Fine, M.D.  
(610) 527-8140

PULMONARY/CRITICAL CARE

David S. Prince, M.D.  
Clarke U. Piatt, M.D.  
Joseph M. Abboud, M.D.  
Catherine A. Riley, M.D.  
Michael E. Post, D.O.  
(610) 527-4896

RHEUMATOLOGY

Donald S. Miller, M.D.  
Kendra K. Zuckerman, M.D.  
Pierre Minerva, M.D.  
Stephanie D. Flagg, M.D., Ph.D.  
Belinda K. Birnbaum, M.D.  
Jay K. Ghadiali, M.D.  
(610) 525-4463



825 OLD LANCASTER ROAD SUITE 320  
BRYN MAWR, PA 19010  
610-527-3800

## **Consent To Treatment / Venue Selection Form**

### **Consent to Medical Care**

I hereby present myself for medical care at Bryn Mawr Medical Specialists Association (“BMMSA”) and voluntarily consent to receive medical care including evaluation and management, routine diagnostic testing, medical procedures and other treatment by authorized agents/employees of BMMSA.

I acknowledge that no guarantees have been made to me regarding the results of the treatment rendered by BMMSA. As a patient, I understand that I will have access to current and complete information about my condition and will, unless otherwise specified, receive continuity of treatment and receive medical care according to a properly sequenced plan of treatment by one of BMMSA’s physicians and/or advance practice providers (APPs).

I acknowledge that before receiving any treatment, I will have an opportunity to ask any questions I may have to the physician and/or APP before I decide whether to give consent for the procedure(s) to be performed and/or treatment rendered. I further acknowledge that all medical procedures and treatment may involve risks, including the risk of an unsuccessful result and/or complications, and that no guarantee has been made as to a result or cure. I have the right, at all times, to be informed of any such risks, as well as the nature of the procedure, the expected benefit, the availability of alternative methods of treatment, and the risks of not agreeing to the treatment plan. I have the right to consent to or refuse any proposed procedure and/or treatment at any time prior to its performance.

### **Venue Selection Agreement**

**NOTICE: In consideration for all current and future medical treatment provided by BMMSA, any legal claims or civil actions, including, but not limited to, a claim for medical malpractice in any way related to the evaluation, procedures, treatment and all following medical services provided by BMMSA or its agents/employees, shall be brought solely in the courts of the county in which care is provided, in the Commonwealth of Pennsylvania.**

If you do **not** agree with the above, you must **initial here** \_\_\_\_\_ or you will be bound by the above.  
**Initials**

**Patient Name (print):** \_\_\_\_\_ **Patient Date of Birth:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date signed:** \_\_\_\_\_

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**\*FOR BMMSA USE ONLY\***

**Patient Account Number:** \_\_\_\_\_

# BRYN MAWR MEDICAL SPECIALISTS ASSOCIATION

## Patient Registration Form

**PLEASE PRINT CLEARLY**

Date \_\_\_\_\_

Account Number \_\_\_\_\_

PATIENT INFORMATION						
Patient's Last Name:		First Name:		Middle Initial:	Date of Birth:	Sex: <input type="checkbox"/> Male (M) <input type="checkbox"/> Female (F)
Patient's Street Address:				Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> W		Gender Identity: <input type="checkbox"/> Transgender Male (FTM) <input type="checkbox"/> Transgender Female (MTF) <input type="checkbox"/> Genderqueer (G) <input type="checkbox"/> Other (O)
City:		State, ZIP: <small>(9 digit if known)</small>		Patient's Home Phone #:		Patient's Cell Phone #:
Billing Street Address of Responsible Party (if different from above):				Race: <input type="checkbox"/> African-American <input type="checkbox"/> Asian <input type="checkbox"/> Caucasian <input type="checkbox"/> Other		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
City:		State, ZIP:		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Other: _____		Email:
Employer's Name:				Work Phone #:		
Pharmacy Name, Address, and Telephone #:						
Referring Physician's Name and Telephone #:				Primary Care Physician's Name and Telephone #:		

INSURANCE INFORMATION		
<b>Primary Insurance Company Name:</b>		
Identification or Policy Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:
<b>Secondary Insurance Company Name:</b>		
Identification Number:	Group Number:	Insurance Company Phone #:
Name of Policyholder:	Patient's Relationship to Policyholder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Dependent <input type="checkbox"/> Other	
Policyholder's Date of Birth:	Policyholder's Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Effective Dates of Insurance:

EMERGENCY CONTACT/PARENT OR GUARDIAN OF PATIENT		
Name:		Relationship To Patient: <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Child <input type="checkbox"/> Other
Home Phone #:	Cell Phone #:	Work Phone #:

### AUTHORIZATION AND RELEASE

- \* I authorize any holder of medical information about me to release this information to the Centers for Medicare and Medicaid Services, my insurance company or its intermediaries or carriers, or to this physician's office.
- \* I authorize direct payment of medical benefits and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Medicare supplemental carrier, private insurance, and any other health plan to Bryn Mawr Medical Specialists Association ("BMMSA"). I further agree to allow BMMSA to file an appeal on my behalf with my health plan. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing.
- \* I understand that I am financially responsible for all charges whether or not paid by said insurance.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**Please hand this form and your insurance cards to the Receptionist.**