



## HOWARD MENIKOFF, M.D. PC

**MANHATTAN: 212.473.7892**  
2 Fifth Avenue, New York, NY 10011

**BROOKLYN: 718.338.1313**  
1321 E. 7 Street, Brooklyn, NY 11230

**THE HAMPTONS: 631.998.4054**  
118 Beach Road, Westhampton Beach, NY 11978

### Patient Information

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Name

Date of Birth (mm/dd/yyyy)

Street Address

City

State

Zip Code

Email Address

Home Phone

Work Phone

Cell Phone

### Insurance Information

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Insurance Name

Policy Number

Group Number

Issued To

### Signature on File/Release Information

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The undersigned hereby authorizes the release of any information relating to all claims for the benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered or for services to be rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(name of insured) (name of insurance company)

to pay and hereby assign directly to Howard Menikoff, M. D. all benefits, if any, otherwise payable to me for his services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that my insurance when received by me and paid to Howard Menikoff, M. D. will be credited to my account, in accordance with the above said assignment.

\_\_\_\_\_  
patient's or authorized signature

\_\_\_\_\_  
date