Albany Medical College
Faculty Group Practice General Acknowledgement

47 New Scotland Avenue, Albany, New York 12208-3478

PROVIDER: ALBANY MEDICAL COLLEGE*  
*Albany Medical College includes multiple physician practices, such as Surgery, Medicine, Women’s Health, Pediatrics and Neurosciences. This acknowledgement applies to any Albany Medical College physician practice.

PATIENT: ____________________________________________

Medicare
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Albany Medical College for any services furnished to me by that provider. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature of Beneficiary/Patient ________________________________ Date ______________

If the patient is physically or mentally unable to sign:

Name of Patient ____________________________________________

By: _______________________________________________________

Signature of Individual Signing on Patient’s Behalf __________________________ Date ______________

Address of Individual Signing on Patient’s Behalf

I am signing on behalf of the patient in my capacity as: (check one of the following boxes and complete the section below entitled “Reason patient unable to sign”)  
☐ legal guardian or representative  
☐ representative payee (a person designated by the Social Security Administration or other governmental agency to receive an incompetent beneficiary’s monthly cash benefits)  
☐ relative  
☐ friend  
☐ representative of agency or institution usually responsible for providing patient’s care  
☐ representative of governmental agency providing assistance to patient  
☐ If none of the above are available, representative of AMC

Reason patient unable to sign: __________________________________________

NON MEDICARE
I hereby assign all medical and surgical benefits to which I am entitled, including private insurance benefits, and any other health plan benefits to Albany Medical College.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that any insurance benefits are subject to verification by Albany Medical College and that I will remain responsible for any unpaid charges whether or not covered by this assignment to the full extent permitted by law. I hereby authorize said assignee to release all information necessary to secure the payment.

Name of Insurance Company _____________________________________________

Insurance ID # ________________________________________________________

Signature of Patient/Legal Guardian or Representative (POA) __________________________ Date ______________

Relationship to Patient: ________________________________________________ Date ______________

☐ I am in receipt of the following:  
☐ Albany Medical Center Notice of Privacy Practices  
☐ Albany Medical College Financial Policy

Signature __________________________________________ Date ______________