Proof of Identity Acknowledgement

By signing this form, you are acknowledging that you understand that the Joseph P. Addabbo Family Health Center will only utilize any valid form of personal identification (driver's license, passport, other government-issued ID) for the sole purpose of verifying insurance coverage to cover the cost of your medical treatment and services. You are not required to provide your Social Security Number.

Joseph P. Addabbo Family Health Center

www.addabbo.org

STATE OF _____

COUNTY OF _____

I, _____

in the county of _____ in the state of _____

do hereby attest that:

1. My full and legal name is _____
2. Other name(s) you may have _____
3. My current address is _____
4. My email address is _____
5. My phone number is (_____) _____
6. As proof of identity, I have presented the health center's staff the following **2 forms of ID** (one of which **must** be a photo ID):
   1. _____ 2. _____
7. I understand that the purpose of this document is to demonstrate that I am the proven (person) patient of JPA _____
8. I swear that all of the aforementioned information is true.

_____
Patient Signature

_____ _____

Received by JPA Agent

_____ 20 _____.

PLACE STAMP HERE

Please return completed form to:
Joseph P. Addabbo Family Health Center
6200 Beach Channel Drive
Arverne, NY 11692
ATTN: ACM Registration Supervisor

Jan 2022