

Kern Augustine Conroy & Schoppmann, P.C.

1325 Franklin Avenue
Garden City, NY 11530
(516) 294-5432

Physician Advocacy Program (MLMIC)
Application

Name: _____

Name of Practice _____

Address of Practice: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail: _____

Choose one:

Basic Program **\$110**

Office of Professional Medical Conduct (only)

- OR -

Comprehensive Program **\$455**

Office of Professional Medical Conduct

HIPAA (Office of Civil Rights)

Medicare Fraud Defense

Medicare Quality Improvement Organization

Healthcare Criminal Authorities

I have read the Program Description and Agree to its terms.

Enclosed is my check for \$ _____

Credit Card: Visa ___ MasterCard ___ American Express ___

Card #: _____ Expiration Date: _____/_____-_____

Signature: _____ Authorized Amount \$ _____

By signing this application I hereby authorize Kern Augustine Conroy & Schoppmann, P.C. to charge my credit card for the authorized amount stated above. I understand that the charge will appear on my credit card statement as "Kern Augustine"