

**Kern Augustine Conroy & Schoppmann, P.C.**

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

**Physician Advocacy Program (MSSNY)**  
**Application**

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

Name of Practice \_\_\_\_\_

Address of Practice: \_\_\_\_\_

\_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-Mail: \_\_\_\_\_

**Choose one:**

**Basic Program** ..... **\$150**

Office of Professional Medical Conduct (only)

**- OR -**

**Comprehensive Program** ..... **\$495**

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"