

PATIENT INFORMATION

MR. _____ **DATE:** _____
MRS. _____
NAME MISS. _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____

ZIP: _____ **HOME PHONE:** _____ **DATE OF BIRTH:** _____

AGE: _____ **MARITAL STATUS:** _____ **SOCIAL SECURITY #:** _____

NEXT OF KIN: _____ **RELATIONSHIP:** _____

NEXT OF KIN PHONE: _____

PATIENTS EMPLOYER: _____

EMPL. ADDRESS: _____ **CITY:** _____

PHONE #: _____

Spouses or Policyholder's EMPLOYER: _____

ADDRESS: _____

RESPONSIBLE PARTY (SPOUSE/ETC.) NAME: _____

ADDRESS: _____ **CITY:** _____

STATE: _____ **ZIP:** _____ **RELATIONSHIP:** _____ **DOB:** _____

HOME PHONE #: _____ **WORK PHONE #:** _____

PRIMARY INSURANCE / HMO : _____

ID / SUBSCRIBER #: _____ **GROUP #:** _____

INS. ADDRESS: _____ **/ P.O. BOX #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ - _____

INS PHONE #: _____

SUBSCRIBERS NAME (Covered Persons Name): _____

SECONDARY INSURANCE / HMO: _____

ID / SUBSCRIBER #: _____ **GROUP #:** _____

ADDRESS: _____ **/ P.O. BOX #:** _____

CITY: _____ **STATE:** _____ **ZIP:** _____ - _____

INS PHONE #: () _____

SUBSCRIBERS NAME (Covered Persons Name): _____

REFERRING PHYSICIAN: _____ **PHONE:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

Due to the recent changes in the healthcare insurance industry we are required to have you sign and date this form.

It is the patient's responsibility to know their exact insurance coverage. In the event you fail to notify us about any changes in your coverage you hereby agree to have those claims become your responsibility.

Signature_____

Date_____

OFFICE FINANCIAL POLICY

Effective Date: 1/1/95

All patients must complete our Patient Information Sheet before seeing the doctor.

Regarding Insurance's & HMO's We Participate With:

You are responsible to supply our staff with your completed insurance forms(if applicable) and your identification cards. Also, you must supply our staff with all referral and/or authorization forms PRIOR to seeing the doctor. THERE WILL BE NO EXCEPTIONS.

****If you do not have the proper referral or authorization forms required by your insurance carrier, YOU MUST EITHER RESCHEDULE OR PAY FOR THE SERVICES IN FULL. Subsequently, if we are paid by your insurance or HMO, we will refund you the amount of the overpayment. Also, if your insurance carrier declines your claim due to the lack of a referral or pre-authorization, you will be responsible for the balance.**

Regarding Non-Participating Insurances:

The bill is your responsibility and is due within 60 days from the date of service, whether or not your insurance company will pay for the services. Your insurance policy is a contract between you and your insurance company. Our office is not a part of that contract.

Regarding Non-Participating Insurance's "Usual And Customary Rates":

Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Thank you for understanding our Office Financial Policy. Please feel free to let us know if you have any question or concerns.

I have read the above Office Financial Policy, I agree and understand its terms.

Signature of Patient or Responsible Party

Date_____

Signature of Co-Responsible Party

Date_____

DISCLOSURE OR ASSIGNMENT RELEASE:

DISCLOSURE RELEASE: I hereby authorize New Jersey Cardiology Associates to release any information pertaining to my medical and health information as it relates to treatment, payment, or health care operations. Information may be shared to my insurance company, physician, family members, and specific friends.

ASSIGNMENT RELEASE: I authorize payment of all medical benefits directly to New Jersey Cardiology Associates for services rendered.

LIVING WILL: Do you have a living will ?

YES _____

NO _____

DATE: _____