

Central Jersey Internal Medicine Associates, PA

ALL ITEMS MUST BE COMPLETED. PLEASE PRESENT YOUR INSURANCE CARDS AND DRIVER'S LICENSE TO THE FRONT DESK

LAST NAME		FIRST NAME		MAIDEN NAME		BIRTHDATE / /		AGE	
MARITAL STATUS S M WID DIV SEP		SOC. SECURITY #		DRIVERS LICENSE #		HOME TELEPHONE		CELL PHONE #	
ADDRESS				CITY		STATE		ZIP	
YOUR EMPLOYER				OCCUPATION		WORK PHONE #			
EMPLOYER'S ADDRESS				CITY & STATE		ZIP		HOW LONG EMPLOYED:	
REFERRED BY:				EMERGENCY NAME & PHONE # OF FRIEND OR RELATIVE NOT LIVING WITH YOU:			ARE YOU IN THE MILITARY? YES NO		

1) PRIMARY INSURANCE COMPANY NAME		INSURANCE COMPANY ADDRESS:							
INSURANCE POLICY ID #:		INSURANCE GROUP #			IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? YES NO				
NAME OF SUBSCRIBER		SUBSCRIBER SS #:		SUBSCRIBER'S BIRTH DATE		RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER OTHER			
SUBSCRIBER'S EMPLOYER		EMPLOYER'S ADDRESS							

2) SECONDARY INSURANCE COMPANY NAME:		INSURANCE COMPANY ADDRESS:							
INSURANCE POLICY ID #:		INSURANCE GROUP #			IS INSURANCE THROUGH SUBSCRIBER'S EMPLOYER? YES NO				
NAME OF SUBSCRIBER		SUBSCRIBER SS #:		SUBSCRIBER'S BIRTH DATE		RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DAUGHTER OTHER			
SUBSCRIBER'S EMPLOYER		EMPLOYER'S ADDRESS							

PATIENT CONFIDENTIALITY - It is our policy to call you to confirm your scheduled appointment and/or procedure, and to report test results. Due to the Privacy Rule, we can only release information to those you list below.

NAME	RELATIONSHIP	TELEPHONE #

ARE WE ABLE TO LEAVE A MESSAGE ON YOUR ANSWERING MACHINE _____ Yes _____ No
 ARE YOU ABLE TO RECEIVE CALLS AT YOUR PLACE OF BUSINESS? _____ Yes _____ No
 IF YES, CAN WE STATE WHO AND FROM WHERE WE ARE CALLING? _____ Yes _____ No
 DO WE HAVE PERMISSION TO RELEASE HEALTH INFORMATION TO OTHER PROVIDERS IN CHARGE OF YOUR HEALTHCARE? _____ YES _____ NO

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. THE PATIENT IS RESPONSIBLE FOR FURNISHING OUR OFFICE WITH ALL THE INFORMATION REQUESTED ABOVE THE PATIENTS IS ALSO RESPONSIBLE FOR FURNISHING ANY NECESSARY INSURANCE FORMS TO THE OFFICE PRIOR TO HOSPITALIZATION OR OFFICE SURGICAL PROCEDURES.

INSURANCE AUTHORIZATION & ASSIGNMENT, & PAYMENT RESPONSIBILITY - I HEREBY CENTRAL JERSEY INTERNAL MEDICINE TO FURNISH INFORMATION TO ANY AND ALL INSURANCE CARRIERS CONCERNING MY MEDICAL RECORDS AND TREATMENTS. I HEREBY ASSIGN TO THE PHYSICIANS ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF AND MY DEPENDENTS. I ACKNOWLEDGE AND UNDERSTAND THAT I AM RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND ALL THE CHARGES INCURRED FROM THOSE SERVICES. ALTHOUGH I HAVE REQUESTED THE PRACTITIONER TO BILL MY INSURANCE COMPANY ON MY BEHALF, I CLEARLY UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE FOR ANY REASON. I WILL ALSO BE RESPONSIBLE FOR ANY CO-PAYS, CO-INSURANCE AMOUNTS, AND DEDUCTIBLES. ANY PAYMENTS MADE DIRECTLY TO THE PATIENT AND OWING TO THE PHYSICIANS WILL BE REMITTED PAYABLE TO CENTRAL JERSEY INTERNAL MEDICINE. I AGREE THAT IF MY ACCOUNT IS REFERRED TO AN OUTSIDE AGENCY OR ATTORNEY FOR COLLECTION, I WILL BE RESPONSIBLE FOR AN ADDITIONAL COLLECTION FEE OF FIFTY DOLLARS (\$50.00) OR 20% OF THE BALANCE OWED, WHICHEVER AMOUNT IS GREATER.

Signature

Date

Signature

Date