CENTRAL JERSEY INTERNAL MEDICINE ASSOCIATES PA

Thomas A. Schwartzer, MD, PhD
Abigail Lore, MD
Deepak K. Jain, MD
Christina Wang-Epstein, MD, PhD
Manan Pandya, DO
Hiran Patel, MD

Adriana Ackerman, APN, BC
Lauren Ferges, APN
Kinjel Patel, APN
Allison Favale, PA
Mary Elizabeth Hohner, RD, CDE

75 Veronica Ave, Suite 204
Somerset, NJ 08873
Phone: 732-828-0002
Fax: 732-828-0153

111 Union Valley Rd, Suite 203
Monroe Township, NJ 08831
Phone: 609-655-2255
Fax: 609-655-2253

Date: _____

I, _____ have received the packet containing the **FINANCIAL**, **HIPAA**, and **MEDICATION/REFILL** policies to read, acknowledge, and I agree to the terms and conditions of each policy. If you have any questions, please speak with any front desk receptionist in office or call 732-828-0002, opt 2.

1. I hereby authorize the release of any medical information for the purpose of processing insurance. I hereby assign all medical benefits to which I am entitled to Central Jersey Internal Medicine Associates. I hereby assign my insurance benefits to be paid directly to the healthcare provider. A photocopy of this assignment is considered as valid as the original.
2. I hereby authorize Central Jersey Internal Medicine Associates and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
3. I hereby authorize Central Jersey Internal Medicine Associates, PA to obtain/have access to my medication history.

I have also confirmed all my information (address, phone numbers, insurance, etc.) with the front staff either in writing or verbally.

Date of Birth:_____

Print Name:_____

Signature:_____