

Patients Name
Address
City, State, Zip

Women's Healthcare
Medical-Surgical Specialty Group
135 Newton Sparta Road Suite 201
Newton, New Jersey

Provider
Appt Date, Time

PATIENT INFORMATION

Patient Name _____ SS# _____ - _____ - _____
Address _____ Date of Birth _____
Address _____ Age _____
City, State, Zip _____ First Day of Your Last Period _____
Email _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext _____
Marital Status (circle one) Widowed Married Single Divorce

SIGNIFICANT OTHER/ EMERGENCY CONTACT PERSON

Name _____ Phone _____
Address _____ Relation to Patient _____
_____ Date of Birth _____

INSURANCE INFORMATION

Primary Insurance _____
Policy # _____ Group # _____
Subscriber's Name _____
Subscriber's SS # _____
Subscriber's Date of Birth _____ SS# _____
Subscriber's Address _____
Relationship to Patient Self Spouse Child

Secondary Insurance _____
Policy # _____ Group # _____
Subscriber's Name _____
Subscriber's SS # _____
Subscriber's Date of Birth _____ SS# _____
Subscriber's Address _____
Relationship to Patient Self Spouse Child

OUTSIDE LABS

Outside labs maybe used for testing the following procedures: lab work, cultures and pap smears. If we participate with your insurance carrier we will send it to the lab they direct us to, otherwise we will send the specimens to labs which we use for the quality of service. Please specify if there is a lab your carrier has an agreement with:

Lab (circle one) Quest Labcorp LabOne Newton Memorial Hospital

Pharmacy _____ Pharmacy Phone _____

Primary Care Physicain _____ Phone Number _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I understand that payment of authorized benefits from Medicare, Medicaid, and/or any Insurance Carrier listed, may be made to me or on my behalf to the provider listed on this form, for any services furnished to me by the physician/supplier. I authorize any holder of medical information about me to release it to the Division of Family Services, the Health Care Financing Administration, listed insurer and or agents of the company and or the listed responsible person(s), any information needed to determine these benefits or the benefit for the related services.

- I acknowledge that I have received information regarding my rights to privacy of information under HIPPA regulations
- I further acknowledge that if I want my protected health information disclosed, I must make that request to the staff and sign a disclosure release.

Print Name _____

Signature: _____ Date: _____

GUARANTEE OF PAYMENT: In consideration of services rendered to the patient named herein, I agree to be financially responsible and to pay charges for all services ordered by the physician (s). I understand that any balance due as a result of being uninsured or under-insured is payable immediately. I further understand that if I fail to maintain any payment, my account may be forwarded to their collection agent and /or attorney.

PRE-CERTIFICATION/REFERRALS: I understand that if my insurance has a pre-certification or authorization requirement, it is my responsibility to notify the carrier of services to be rendered according to the plans provisions. I understand that if my insurance requires referrals it is my responsibility to produce one as needed prior to seeing the physician. Failure to do so will result in reduction or denial of benefit payment and I will be responsible for all balances.

SIGNATURE: _____ RELATIONSHIP: _____

WITNESS: _____ DATE: _____

CONSENT FOR TREATMENT

Upon my admission to the Northwest NJ Medical Surgical Specialty Alliance, I do voluntarily CONSENT to the rendering of care at the physicians and personnel, in their judgment, deem to be necessary for my health and well being during my admission to said department.

This consent shall include medical examination and diagnostic testing as well as minor surgical procedures (including suturing), cast application/removals and shall also include the carrying out of the orders of my treating physician by office personnel. I acknowledge that neither the physician nor the office personnel has made any guarantee or assurance as to the results that may be obtained.

I authorize the practice to discuss my health care with the following person(s) Please circle.

No One Husband Wife Mother Father Child Other

Name and Relationship must be written in order for us to comply with NPP.(Notice of Privacy Practices)

I authorize Medical Surgical Specialty Group to leave health care information on my:

Please Circle One: Cell Phone Home Phone Neither.

I HAVE READ AND UNDERSTAND THIS CONSENT.

Patient's Signature (To be signed by parent or legal guardian if patient is a minor under the age of 18, or a mentally incompetent patient) (Relationship)

Date: _____ Time: _____ AM/PM

Witness Signature

