THE MEDICAL GROUP OF NEW JERSEY

Medgroupnj.com
908-520-1927

Date: _____

Name: _____ Email: _____ Date of Birth: _____

Mailing Address: _____

Physical Address (if different): _____

Home#: _____ Cell#: _____ Work#: _____

Social Security: _____ Marital Status: _____

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Refused to Report Language: _____

Race: ☐ White ☐ Black/African American ☐ Hispanic ☐ Asian ☐ American Indian/Alaska Native
☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Refused to Report

Primary Care Physician: _____ Phone#: _____

Pharmacy: _____ Phone#: _____

Advanced Directive: ☐ Living Will ☐ DNR ☐ DNI ☐ POLST ☐ None

Employment: ☐ Employed ☐ Not Employed ☐ Self-employed ☐ Retired ☐ Active Military Duty ☐ Student ☐ Other

For office delays & closing notifications due to inclement weather, how may we contact you?

☐ Text Message ☐ Phone Call Your preferred phone#: _____

Is today's appointment a Workman's Compensation Claim or Motor Vehicle Accident? ☐ Yes ☐ No
If yes, please notify a front-end staff member & provide the necessary information.

Prescription Card ID#: _____

Primary Insurance Company: _____

Policy ID #: _____ Group #: _____

Policyholder's Name: _____ DOB: _____ Relationship to Patient: _____

Secondary Insurance Company: _____

Policy ID #: _____ Group #: _____

Policyholder's Name: _____ DOB: _____ Relationship to Patient: _____

*Person responsible for bill if patient is under 18 years of age: _____

Date: _____

Patient Name: _____ Date of Birth: _____

_____ I DO authorize The Medical Group of New Jersey _____ to release my Protected Health Information (PHI) to the following list below.

_____ I DO NOT authorize The Medical Group of New Jersey _____to release my Protected Health Information (PHI) to anyone except myself.

Emergency Contact & Relationship: _____

Phone #: _____

Please list any other contacts below:

Name	Relationship	Phone#
Name	Relationship	Phone#

It is OK to leave a message on my answering machine at the following telephone number(s):

_____ _____

I authorize payment directly to the physician of the surgical and/or medical benefits if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I authorize The Medical Group of New Jersey _____to release any information acquired during my treatment to process insurance claims.

I have received a copy of the patient privacy rights as outlined by HIPAA.

Patient signature: _____ Date: _____

PAYMENT POLICY

At The Medical Group of New Jersey _____ we are dedicated to providing our patients with the best possible care and service. In order to keep your out-of-pocket expense to a minimum, we ask your help by understanding and cooperating with our payment policy.

We participate with most major insurance companies. It is your responsibility to verify that our doctors are in your plan prior to services being rendered. If you come to an appointment without your insurance information, you will be required to pay in full at the time of visit. If your insurance plan requires a referral to see a specialist, it is your responsibility to bring the referral with you.

If we do not participate with your insurance plan, you will be required to pay in full at the time of the office visit. As a courtesy to you, we will submit an insurance claim on your behalf. We emphasize that as your medical provider our relationship is with you, not your insurance company. Patients without health insurance are responsible for payment at the time of their visit.

All copayments are due upon check-in. A $25.00 administrative charge will be incurred if we have to bill you for a copayment.

We understand that occasionally situations come up that are beyond your control. In these instances, we do request you extend us the courtesy of 24 hour notice prior to canceling your appointment. TMGNJ may charge $50.00 for missed office visit appointments and cancellations received less that 24 hours prior to the appointment time, except in case of medical emergency. Cancellations for testing must be made no later than 48 hours prior to the test. TMGNJ _____may charge $100.00 for missed test appointments. This charge must be paid prior to rescheduling the test.

Our office accepts Visa, MasterCard, Discover, and American Express for your convenience, as well as cash and check. If a check is returned for insufficient funds, you will be charged a $25.00 administrative fee plus all bank charges. All account balances are due within 30 days. All patients with a past due account must meet with a patient account specialist prior to receiving new services. All balances that reach 60 days past due will be sent to a collection agency and at that time you will be discharged from the practice until your account is paid in full.

I have read and understand the payment policies of The Medical Group of New Jersey .

Patient Signature: _____ Date: _____