

The Medical Group of New Jersey - Sussex Cardiology

Date: _____ Email: _____

Name: _____ 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: _____

**The Medical Group of New Jersey
Sussex Cardiology
Authorization for Disclosure of Information**

Date: _____

Patient Name: _____

Date of Birth: _____

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

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

Emergency Contact & Relationship: _____

Phone #: _____

Please list any other contacts below:

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 Sussex Cardiology to release any information acquired in the course of my treatment to process insurance claims.

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

Patient signature: _____ **Date:** _____

The Medical Group of New Jersey Sussex Cardiology Payment Policy

At The Medical Group of New Jersey Sussex Cardiology, 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 you do not have a referral, your appointment will need to be rescheduled.

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 cardiology providers, 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 may be incurred if your copayment is not paid within 7 days of your visit.

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 Sussex Cardiology will charge \$50.00 for missed provider visits or tests, as well as any cancellations received less than 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.

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 \$30.00 administrative fee plus all bank charges. All patients with a past due account must contact a patient account specialist at (908) 979-1621, ext: 110 prior to receiving new services. All balances that reach 90 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 Sussex Cardiology.

Patient Signature: _____ **Date:** _____