Perinatal Diagnostic Centers
of New York and New Jersey

26 Journal Square, Suite 700
Jersey City, New Jersey 07306
1-833-732-1131 Fax: 201-608-0497

NAME (First) _____ (Middle) _____ (Last) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Home Address _____
Email: _____ Street City State Zip Code
Date of Birth _____ Age _____ Sex _____ Social Security # _____
Employer _____ Occupation _____

GUARANTOR INFORMATION (If other than patient)
NAME _____ Relationship to Patient _____ Date of Birth _____
Home Phone _____ Work Phone _____ Social Security _____
Home Address _____
Street City State Zip Code
Emergency Contact _____ **Daytime Phone #** _____

PRIMARY INSURANCE CO _____
Claims Address _____
Street / P.O. Box City State Zip Code
POLICY # _____ **GROUP #** _____
Policy Holder's Name _____ DOB _____ SSN _____ Sex _____
Policy Holder's Employer _____ Work Phone _____
Relationship of Patient to Policy Holder _____Self _____ Spouse _____ Child _____ Other

SECONDARY INSURANCE CO _____
Claims Address _____
Street / P.O. Box City State Zip Code
POLICY # _____ **GROUP #** _____
Policy Holder's Name _____ DOB _____ SSN _____ Sex _____
Policy Holder's Employer _____ Work Phone _____
Relationship of Patient to Policy Holder _____Self _____ Spouse _____ Child _____ Other

Is this visit related to an ____ Auto Accident ____ Work Injury If so, Please Complete below
WORKMAN'S COMPENSATION / AUTO ACCIDENT CLAIM INFORMATION
Ins. Co. Name _____
Claims Address _____
Contact Name / Agent _____ Phone # _____
Date of Accident/Injury _____ **CLAIM #** _____

Signature _____ **Date:** _____

PATIENT FINANCIAL AGREEMENT

I hereby authorize Dr. _____ to apply for benefits on my behalf for services rendered. I authorize the release of any necessary information, including medical information, for this or any related claim to my insurance company in order to determine these benefits payable. I request that payment of authorized benefits be made payable to Dr. _____ on my behalf.

- ✓ **We participate with Medicare, Carefirst BCBS and certain HMO/PPO programs. Please confirm with your insurance company that we are listed as participating providers. By contract, covered charges will be paid directly to us by your insurance company. Any applicable co-insurance and deductible payments are due at the time of service.**
- ✓ **If we do not participate with your insurance you will be required to pay in full for charges at the time of service. As a courtesy, we will submit the insurance form on your behalf requesting that payment be made directly to you for reimbursement.**
- ✓ **A $25.00 fee will be charged to all patients for any returned checks.**
- ✓ **I understand that I may be charged a 20.00 cancellation fee for any appointments not cancelled within a 24 hour time frame.**
- ✓ **I understand that I am financially responsible for any non-covered and/or denied charges incurred on my behalf.**
- ✓ **I have also reviewed or have been provided with a copy of Dr. _____ Notice of Privacy Practices.**
- ✓ **A copy of this agreement may be used in place of the original.**

Printed Name: _____

Signature _____ Date_____