Jersey Medical Weight Loss Center/ Aparna Medical Associates
1527 Route 27-Suite 2100
Somerset, NJ 08873

Date: ____________

PATIENT INFORMATION

Name: ______________________ ______________________ ______ Male or Female

LAST FIRST MI

Birth Date: ___________ Email Address: ______________________________

Home Address: ______________________________ City: ____________________

State ______ Zip Code ________ Home Phone ____________ Cell Phone ______________

Employed By: ______________________ Occupation: ______________________

Business Address: ______________________ Phone ______________________

Emergency Contact Name: ______________ Relationship: __________ Phone __________

PAYMENT/ INSURANCE INFORMATION

Active Medical Insurance Coverage: Yes ___ No___ Self Pay: Yes___ No___

Insurance Plan: ____________________ Responsible Person: Self Spouse Parent Other

Subscriber Name: ________________ Subscriber ID: ______________ Birth Date: __________

Additional Insurance? Yes__ No___ Insurance Plan: ____________ Subscriber Name: ______________

Relation to Patient ____________ Subscriber ID: ______________ Birth Date: ______________

GENERAL INFORMATION

Name of Primary Care Physician: ______________________ Phone: __________________

Pharmacy Name :________________ City/State: ______________ Phone:__________________

Can we leave messages on your answering machine/ voice mail about medication or labs results? Yes __ No__

Can we use your email for Correspondence? Yes___ No___

How did you hear about our medical practice? ______________________________________

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Patient Enrollment Form (Page 2)

PATIENT ACKNOWLEDGEMENT

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We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required for you to review and if requested, give you the Privacy Notice that outlines our privacy practices, our legal duties and your right concerning your health information. We must follow the privacy practices that are described in our Privacy Notice while it is in effect. PLEASE READ OUR PRIVACY NOTICE BEFORE SIGNING.

I have reviewed and /or received a copy of the office's Notice of Privacy Practices: ____________________ __________

Signature Date

ASSIGNMENT AND RELEASE

I, the undersigned have medical insurance coverage with ______________________________ and assign directly to Dr. Aparna Chandrasekaran (Jersey Medical Weight loss center/ Aparna Medical Associates) all medical benefits, if any , otherwise payable to me for services rendered. I authorize the physician to release all information necessary to secure the payment of benefits. Also, I understand that I am **financially responsible for all charges** if not paid by the insurance and authorize the use of my signature on all my insurance submissions.

SELF PAY PLAN

I understand that my office visit will not be billed to my Insurance and agree to pay "out of pocket" for my office visits at Jersey Medical Weight loss under the care of Dr. Aparna Chandrasekaran.

- ☐ I give expressed consent to release my health-related information to my insurance company without any restriction.
- ☐ I do not wish to share any health-related information with my insurance company

- ☐ I do not have Health Insurance coverage, and I agree to pay for the services at the time of the visit.

By signing below, you certify that all information provided is true, correct and complete.

______________________ ____ ____________________

Signature Print Name Date