JERSEY MEDICAL WEIGHT LOSS
1527 Route 27 – Suite 2100
Somerset, NJ 08873
(732 659-6650 – Office (732) 659-6649 – Fax
www.jerseymedweightloss.com

Date_______________ **PATIENT INFORMATION** Email:______________________

Name: _______________________________________ ___________________________________ Soc. Sec. No. _________________
Last First MI

Male or Female Birth Date:_____________ Ethnicity:_________ **Marital Status:** Single Married Widowed Separated Divorced

Address: ____ City:__________________________________

State ______ ZipCode __________ Home Phone: _____________________________ Cell Phone: __________________________

Employed By:____ Occupation:____________________________

Business Address: ____ Phone:______________________

Emergency Contact Name: _______________________________________ Relationship: ____________ Phone:________________

INSURANCE INFORMATION

Insurance Plan: ____ Responsible Person: Self Spouse Parent Other

Subscriber Name:___________________________ Subscriber ID:_________________________________ Date of Birth:__________

Additional Insurance?___ Yes ___ No Insurance Plan: _________________________Subscriber Name:___________________________

Relation to Patient______________________ Subscriber ID:_______________________________________ Date of Birth:__________

GENERAL INFORMATION

Name of Primary Care Physician: ____ Phone: ( ) ___________________

Address:____ When did you have your last physical exam?: ____________

Pharmacy Name:______________________________ Location:_________________________________ Phone:__________________

Can we leave voice messages on your answering machine/voice mail about medication or lab results? _____Yes _____No

How did you hear about our medical practice? ____

PAYMENT POLICY

I understand that payment and co-payments are due at the time services are rendered, according to the most current Fee Schedule. We do not accept post-dated checks and all returned checks will be charged $30. I agree that if my account is referred to a collection agency, I will be responsible for all collection costs, attorney fees and court costs.

____________________________________ ___________
(Signature) (Date)

Patient Enrollment Form - (page 2)

PATIENT ACKNOWLEDGEMENT

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 (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** whether or not paid by the insurance and authorize the use of this signature on all my insurance submissions.

____ ______________

Patient Signature Date

MEDICARE AUTHORIZATION

I authorize payment of any Medicare benefits for services rendered by Aparna Medical Associates to be release to Dr. Aparna Chandrasekaran (Aparna Medical Associates. I authorize any holder of medical information about me to be release to the Healthcare Provider, Finance Administration, and its agents any information needed to determine these benefits or the benefits payable for related services. I understand that my signature request payment be made and authorizes release of medical information to pay the claim. If "Other Insurance" is indicated on item 9 of the HCFA-1500 form, other approved claim form or electronically submitted claim(s), my signature authorizes release of information to the insurer or agency shown. In Medicare assigned cases, the physician or the supplier agrees to accept the charges determined by the Medicare carrier as the full charge and the patient is responsible for its deductible, co-insurance and non-covered services. Co-Insurance and the deductible is based upon the charge determination of the Medicare provider.

____ ______________

Patient Signature Date