115 Christopher Columbus Drive
Suite 301
Jersey City, New Jersey 07302
201-706-3808
http://www.drsmedicalassociates.com/

WELCOME TO DRS MEDICAL ASSOCIATES LLC! PLEASE COMPLETE THE FORM LEGIBLY AND ENTER AS MUCH INFORMATION AS YOU CAN

TODAY'S DATE:_____

PATIENT'S Last Name: _____First _____Middle:_____

Address_____

Birth date _____ Soc Sec #_____ Sex (M)_____(F)_____

Name of Insurance Policy Holder:_____ID #_____

PARENT #1 Last Name: _____First _____Middle:_____

Street Address_____City_____State_____ Zip_____

Cell Phone number_____

Birth date _____ Soc Sec #_____
Employer _____ Occupation _____
Ethnicity: _____Language Spoken: _____
Marital Status:_____

Email Address_____

PARENT #2 Last Name: _____First _____Middle:_____

Cell Phone _____ Home Phone_____

Street Address_____City _____State_____ Zip_____

Birth date _____ Soc Sec # _____
Employer _____Occupation _____
Ethnicity: _____Language Spoken: _____
Marital Status:_____

Email Address:_____

Preferred Pharmacy Name and Phone Number:_____

How did you hear about our office?_____

ALL CHILDREN'S NAMES / DATES OF BIRTH

_____

AUTHORIZATION FOR VERIFICATION OF INFORMATION: I, the undersigned, hereby certify that to the best of my knowledge the statements contained herein are true. I authorize the Practice and/or its assignee to verify statements made herein.

RELEASE OF MEDICAL INFORMATION: I, the undersigned, hereby authorize the Practice to release medical information relating to my condition as appropriate to all parties as deemed appropriate by the Practice. I authorize the release of any medical information necessary to process claims for insurance reimbursement or payment. I further authorize payment to the Practice of any medical benefits resulting from medical or surgical services rendered by the Practice. This release shall remain in effect until revoked by me in writing. A photocopy of this release is to be considered as valid as the original.

FINANCIAL RESPONSIBILITY: I, the undersigned, hereby agree to be responsible for all claims and charges incurred on my behalf. I certify that I have insurance coverage and assign directly to the Practice all insurance benefits, if any, otherwise payable to me for services redeemed by the Practice. I, the undersigned, hereby authorize the issue of this signature below on all insurance submissions. I understand that the Practice will bill the insurance company and will be reimbursed for the services rendered to me. In the event the services rendered by the Practice to me are not covered by insurance or my deductible at the time of my visit is not satisfied, I agree and understand that I shall be directly responsible to pay the Practice all fees associated with such service. Additionally, during a preventative exam, I agree and acknowledge that certain services are included and covered under my insurance policy; however, if other services are rendered by the Practice in connection with such preventative exam that are not otherwise covered by my insurance policy as part of the preventative exam, I agree and understand that I am financially responsible for the cost of such services. I agree and understand that I will be expected to pay for such services at the time of each visit. I further agree to pay all collective costs, responsible attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding. If any payment(s)/explanation of benefits are issued directly to me for care received at the Practice, I shall forward such payment(s)/explanation of benefits to the Practice for posting in a timely fashion. In cases of claims being submitted to the insurance carrier, it is my responsibility to financially cover any deductibles, co-payments, co-insurance and non-covered services as stipulated by my specific insurance plan, which may include certain laboratory and/or radiology services. For avoidance of doubt, any laboratory and/or radiology tests that are otherwise not covered by my insurance shall be my financial responsible and I shall remit payment to such testing center directly; I understand and agree that the Practice is not otherwise responsible to cover the costs of such laboratory and/or radiology tests.

MISSED APPOINTMENTS or LATE FOR APPOINTMENTS: I, the undersigned, understand and acknowledge that the Practice maintains the right to directly charge me (as well as every other patient, except Medicaid patients) a No Show fee in the amount of $25.00 if I do not show for my scheduled appointment and/or did not provide the Practice with at least 24 hours notification re cancellation or rescheduling such appointment. If the No Show fee is charged, I agree that I shall promptly make such payment to the Practice. If payment is not made to the Practice, I agree and understand that the Practice reserves the right to not schedule me for another visit until such fee is paid. In case of any cancellation, I will use my best efforts to re-schedule such cancelled visit within 1 to 2 weeks. I also hereby agree and acknowledge that in the event I am ten (10) minutes or later for an appointment, the Practice reserves the right to re-schedule the appointment for another day as mutually agreed between myself and the Practice.

CONFIRMATION OF RECEIPT OF WRITTEN POLCIES: I, the undersigned, hereby confirm and acknowledge receipt of the following written policies of the Practice (which are attached hereto as exhibits) and consent to the terms and provisions found in each policy. With regards to the Notice, please note that a copy of such Notice can be found at the Practice's office and can be reviewed by requesting a copy of the Notice with the Practice

a) Notice of Privacy Practices ("Notice"): I consent to, and authorize, the use and disclosure of my patient health information and insurance/payment information by the Practice and consent to the restrictions contained in the Notice. Other than those releases authorized by HIPAA as described in the Notice, I authorize the Practice to release my patient health information to the following named individuals:

_____ _____

Name and Phone Number Relationship

b) Consent to Access External Prescription History: I understand, agree to, and authorize the Practice and its affiliated providers and staff to access and view the external prescription history for me, which may include past prescriptions from several years ago, from multiple medical providers (whether affiliated or unaffiliated), insurance companies, and pharmacy benefit managers.

c) Vaccination Policy: I have read, understand and agree to the terms and provisions of this Policy.

_____ _____

SIGNATURE AND DATE PRINTED NAME