Phone Number: 201-797-2003 Fax Number: 201-797-7003

OUR FINANCIAL POLICY

Thank you for choosing us for your medical care. The following is a statement of our financial policy which we ask you to read and sign prior to any treatment.

All patients must complete our General Information Form and Medical History Form before seeing the doctor. If you belong to an insurance or managed care plan, please let us know beforehand.

- We accept Cash, Check, and Credit cards.
- If you belong to an HMO or PPO that requires a co-payment, you will be asked to pay this prior to seeing the doctor.

Regarding Medical Insurance

- Your health insurance policy is a contract between you and your insurance company. Any disputes regarding medical coverage should be addressed directly to them.
- If you belong to an HMO,PPO, or any other managed care plan in which we participate, we will automatically file your insurance claim for you. You are responsible for obtaining any required authorizations, pre-certifications, and/or referrals prior to your visit.
- If a treatment or procedure is performed here and is deemed not payable by your insurance company (e.g. annual physicals, preventive immunizations, etc) you will be held responsible for payment in full.
- If you are a Medicare beneficiary, we will file your claim directly with Medicare for you. If you have a secondary insurance, we will balance bill them for the portion Medicare does not pay. However, you remain responsible for filing your own claims with them.

PATIENT'S SIGNATURE____Date ______________

PRINT NAME:____

Phone Number: 201-797-2003 Fax Number: 201-797-7003

General Information

Social Security Number: _____ _____ _____ Today's Date:____________

Patient's Name:____
(First) (Middle) (Last)

Sex:__________ Date Of Birth: ________________ Marital Status:____________________

Email Address:____

Employer: ____
(Name) (Address)

Home #:______________________ Cell #:____________________ Work #:________________

Home Address:____
(Street) (Town) (State) (Zip Code)

**Emergency Contact:______________________________ Relation:______________________
(First and Last Name) (Mother/Father/Spouse/ ETC.)

Cell #:________________________ Home #:_________________________

**Pharmacy:______________________________ Location:____________________________
(Name of Pharmacy) (Street, Town, State, Zip Code)

Assignment of Benefits Authorization

I request that payment of authorized benefits be made to Apex Medical Professionals for any services furnished to me by that provider. I authorize any holder of medial information about me to release to the Health Care Financing Administration and its agents; any information to determine these benefits payable for related services. This authorization may be canceled on my request any time.

____________________________________ ______________________
Signature Today's Date

** This paper shows that we have your signature on file an we will submit your insurance claim for services rendered at our services. Please submit your insurance cards for photocopying.

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Acknowledgement of Receipt of Notice of Privacy Practices:

I acknowledge that I have received Apex Medical Professional's Notice of Privacy Practices. I understand that if I have any questions regarding this notice, I may contact the Privacy Officer.

____ ________________________

(Printed Name) (Date Of Birth)

____ ________________________

(Signature) (Today's Date)

____

(Signature of Parent/Guardian) SPECIFY WHICH PLEASE!!

Phone Number: 201-797-2003 Fax Number: 201-797-7003

Authorization to Disclose Personal Health Information

Please fill in the name and relationship of the person to whom you want us to disclose your personal health information.

If no one, please circle ------- NO ONE

Name	Relationship
1.	
2.	
3.	

I authorize Apex Medical Professionals to disclose my personal health information to the person(s) I have named on this form. I understand that my personal health information may be re-disclosed by the person(s) and may no longer be protected by law.

Note: You have the right to take back (“revoke”) your authorization at any time, in writing, except to the extent that Apex Medical Professionals has already acted base on your permission. If you would like to revoke your authorization, please send a written request to our office. This authorization remains in effect indefinitely, unless otherwise revoked in writing.

Signature: ____ Date: _____________

Phone Number: 201-797-2003 Fax Number: 201-797-7003

Medical History

Do you Smoke: Yes No If yes, Amount _______ Years _______ Packs/Day _______

If ex-smoker, Amount _______ Years _______ Packs/ Day ______

Drink Alcohol? Yes No If yes, Amount _______ Years _______

(Beer, Hard Liquor, Wine) If ex-drinker, Amount________ Years________

	Date:	**Name of DR/Facility:**
Last Mammogram	_________________	________________________________
Last PAP Smear	__________________	________________________________
Last Bone Density	__________________	________________________________
Last Sigmoidoscopy	__________________	________________________________
Last Colonoscopy	__________________	________________________________
Last Tetanus Shot	__________________	________________________________
Last TB Skin Test	__________________	________________________________
Last Flu Shot	__________________	________________________________
Last Pneumonia Shot	__________________	________________________________
Last Hep A Vaccine	__________________	________________________________
Last Hep B Vaccine	__________________	________________________________
Other Vaccines	___________________	________________________________
	___________________	________________________________

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Name: ____ Age: __________ Sex: _________

Date: ____________ Birthdate: __________________ Occupation: ___________________________

Email: ___________________________ Home #: _________________ Cell #: ____________________

Past Medical History: (PLEASE CIRCLE YES OR NO)

Cancer	Yes	No	Migraine	Yes	No
Hypertension	Yes	No	Lung Disease	Yes	No
Diabetes	Yes	No	Injuries	Yes	No
Heart Disease	Yes	No	Sexual Transmitted Disease	Yes	No
Arthritis	Yes	No	Blood Transfusion	Yes	No
Psychiatric Disorder	Yes	No	Anemia	Yes	No
Thyroid Disease	Yes	No	High Cholesterol	Yes	No

Other: _________________________

Allergies:

Medication	Yes	No	____
Food	Yes	No	____
Seasonal	Yes	No	____

Current Medications:

_______________________ _______________________ ___________________________

_______________________ _______________________ ___________________________

_______________________ _______________________ ___________________________

Social History: (Please Circle) **Single** **Married** **Widowed** **Divorced** **Separated**

Children: **Yes** **No** **AGE:** **Illness:**

__________ ____

__________ ____

__________ ____