BRICK WOMEN'S PHYSICIANS, PC 1140 BURNT TAVERN ROAD

ANY CHANGES TO INSURANCE INFO? YES / NO
ANY CHANGES TO ADDRESS/PHONE INFO? YES / NO
PLEASE PRINT

BRICK, NJ 08724

NAME:	NAME:		DATE:	
APT #:				
DATE OF BIRTH:				ZIP:
DATE OF BIRTH:				
PERSONAL E-MAIL ADDRESS: EMPLOYER NAME & ADDRESS: PHARMACY NAME: PHONE #: ADDRESS: DATE OF BIRTH: ADDRESS: ADDRESS: ADTE STATE: ZIP: PRIMARY INSURANCE NAME OF INSURED: DATE OF BIRTH: ADDRESS: APT #: CITY: STATE: ZIP: PHONE: NAME OF INSURANCE COMPANY: SUBSCRIBER ID #: SUBSCRIBER SS #: NAME OF INSURANCE COMPANY: NAME OF INSURANCE COMPANY: SUBSCRIBER ID #: DATE OF BIRTH: SUBSCRIBER ID #: SECONDARY INSURANCE NAME OF INSURANCE COMPANY: NAME OF INSURANCE COMPANY: NAME OF INSURANCE COMPANY: OO YOU GIVE PERMISSION TO LEAVE A DETAILED MEDICAL MESSAGE ON CELL? GROUP #: OO YOU GIVE PERMISSION TO LEAVE A DETAILED MEDICAL MESSAGE ON CELL? OO YOU GIVE PERMISSION TO LEAVE A DETAILED MEDICAL MESSAGE ON CELL? GIVE THE PHYSICIANS AND STAFF PERMISSION TO SPEAK TO THE FOLLOWING PEOPLE REGARDING MEDICAL, INSURANCE, AND EMERGENCY ISSUES. AME: PHONE: RELATIONSHIP: PHONE: RELATIONSHIP: RELATIONSHIP:				
PHARMACY NAME:	PERSONAL E-MAIL	ADDRESS:		
PHARMACY NAME:	EMPLOYER NAME &	. ADDRESS:		
PRIMARY INSURANCE NAME OF INSURED:	PHARMACY NAME: _		PHONE #:	
NAME OF INSURED:	ADDRESS:		CITY:	STATE: ZIP:
ADDRESS:		PRIMAI	RY INSURANCE	
ADDRESS:	NAME OF INSURED		DATE OF BI	RTH:
APT#:CITY:STATE:ZIP:				
RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER PHONE: NAME OF INSURANCE COMPANY: SUBSCRIBER ID #: SUBSCRIBER SS #: IN NETWORK LAB: SECONDARY INSURANCE NAME OF INSURANCE COMPANY: NAME OF INSURED: RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER SUBSCRIBER ID #: SUBSCRIBER ID #: GROUP #: SUBSCRIBER ID #: OO YOU GIVE PERMISSION TO LEAVE A DETAILED MEDICAL MESSAGE ON CELL? YES NO GIVE THE PHYSICIANS AND STAFF PERMISSION TO SPEAK TO THE FOLLOWING PEOPLE REGARDING MEDICAL, INSURANCE, AND EMERGENCY ISSUES. NAME: PHONE: RELATIONSHIP: RELATIONSHIP: RELATIONSHIP: RELATIONSHIP: RELATIONSHIP:	ADT #:	CITY:	STATE:	ZIP:
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SUBSCRIBER ID #:		RFLATI	ONSHIP: SELF / SPOUS	SE / PARENT / OTHER
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		PHONE.		RELATIONSHIP:
PHONE:RELATIONSHIP:		DUCKIE:		,,
	NAME:	PHONE:		RELATIONSHIP:

PLEASE READ AND INITIAL THE FOLLOWING

I AM AWARE THAT ALL BALANCES MUST BE PAID	IN FULL PRIOR TO SCHEDULING ANY NEW				
APPOINTMENTS:					
I AM AWARE THAT BRICK WOMEN'S PHYSICIA	ANS WILL IMPOSE AN INTEREST CHARGE OF (20% APR)				
ON BALANCES BEYOND 60 DAYS FROM DATE OF	F SERVICE:				
AM AWARE THAT I WILL BE CHARGED A \$50.00 FEE FOR MISSED OR CANCELLED APPOINTMENTS					
IF I DO NOT NOTIFY BRICK WOMEN'S PHYSICIANS AT LEAST 48 HOURS PRIOR TO MY SCHEDULED					
APPOINTMENT:					
I AM AWARE THAT ANY NON-COVERED SERVICE	CES WILL BE MY FINANCIAL RESPONSIBILITY:				
I AM GRANTING PERMISSION TO BRICK WOMEN	N'S PHYSICIANS TO VIEW MY PRESCRIPTION HISTORY				
FROM EXTERNAL SOURCES:					
I AGREE THAT THE INFORMATION ABOVE IS COR	RECT AND AGREE TO THE TERMS ABOVE:				
PATIENT SIGNATURE	DATE				
ACKNOWLEDGEMENT OF OU	IR NOTICE OF PRIVACY PRACTICES				
	d or have been given the opportunity to receive				
By signing below, I am "only" giving ackr had the opportunity to receive the Notice o	nowledgement that I have received or have of our Privacy Practices.				
Patient Name or Representative (Print)	Date				
Signature of Patient/Representative					

REVISED 08/2