BRICK WOMEN'S PHYSICIANS, PC
1140 BURNT TAVERN ROAD
BRICK, NJ 08724

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

******PLEASE PRINT******

NAME: ______________________________ DATE: ______________
ADDRESS: ____
APT #: __________ CITY: ______________ STATE: ______ ZIP: __________
HOME #: ______________ CELL #: ______________ WORK #: ______________
DATE OF BIRTH: ______________ SS #: ______________ MARITAL STATUS: S M D W
PERSONAL E-MAIL ADDRESS: ______________________________

EMPLOYER NAME & ADDRESS: ______________________________
PHARMACY NAME: ______________________ PHONE #: ______________
ADDRESS: ______________________ CITY: ____________ STATE: ____ ZIP: ________

PRIMARY INSURANCE

NAME OF INSURED: ______________________ DATE OF BIRTH: ______________
ADDRESS: ____
APT #: __________ CITY: ______________ STATE: ______ ZIP: __________
RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER PHONE: ______________
NAME OF INSURANCE COMPANY: ______________________________
SUBSCRIBER ID #: ______________________ GROUP #: ______________
SUBSCRIBER SS #: ______________________ IN NETWORK LAB: ______________

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: ______________________________
NAME OF INSURED: ______________________ DATE OF BIRTH: ______________
SS #: ______________________ RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER
SUBSCRIBER ID #: ______________________ GROUP #: ______________

DO YOU GIVE PERMISSION TO LEAVE A DETAILED MEDICAL MESSAGE ON CELL? YES NO

I GIVE THE PHYSICIANS AND STAFF PERMISSION TO SPEAK TO THE FOLLOWING PEOPLE REGARDING MEDICAL, INSURANCE, AND *EMERGENCY* ISSUES.

NAME: ______________________ PHONE: ______________ RELATIONSHIP: __________
NAME: ______________________ PHONE: ______________ RELATIONSHIP: __________
NAME: ______________________ PHONE: ______________ RELATIONSHIP: __________

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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 PHYSICIANS** WILL IMPOSE AN INTEREST CHARGE OF **(20% APR)** ON BALANCES BEYOND **60 DAYS** FROM DATE OF SERVICE: _________

I 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 SERVICES** WILL BE MY FINANCIAL RESPONSIBILITY: ________

I AM GRANTING PERMISSION TO **BRICK WOMEN'S PHYSICIANS** TO VIEW MY PRESCRIPTION HISTORY FROM EXTERNAL SOURCES: __________

I AGREE THAT THE INFORMATION ABOVE IS CORRECT AND AGREE TO THE TERMS ABOVE:

_______________________________   _______________________________

PATIENT SIGNATURE   DATE

ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I, hereby acknowledge that I have received or have been given the opportunity to receive a copy of **"BRICK WOMEN'S PHYSICIANS"** notice of privacy practices.

By signing below, I am **"only"** giving acknowledgement that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

_______________________________   _______________

Patient Name or Representative (Print)   Date

____

Signature of Patient/Representative

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