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: _____ PHONE #: _____
ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PHARMACY NAME: _____ PHONE #: _____
ADDRESS: _____ CITY: _____ STATE: ____ ZIP: _____

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY: _____
SUBSCRIBER ID #: _____ GROUP #: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ SUBSCRIBER SS #: _____
APT #: _____ CITY: _____ STATE: _____ ZIP: _____
RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER PHONE: _____

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY: _____
SUBSCRIBER ID #: _____ GROUP #: _____
SUBSCRIBER NAME: _____ DATE OF BIRTH: _____
ADDRESS: _____ SUBSCRIBER SS #: _____
APT #: _____ CITY: _____ STATE: _____ ZIP: _____
RELATIONSHIP: SELF / SPOUSE / PARENT / OTHER PHONE: _____

BY INITIALING HERE, YOU ARE GIVING BRICK WOMEN'S PHYSICIANS PERMISSION TO LEAVE A DETAILED MESSAGE ON YOUR CELL PHONE _____

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

NAME: _____ PHONE: _____ RELATIONSHIP: _____
NAME: _____ PHONE: _____ RELATIONSHIP: _____

REVISED 05/09/2018

NAME: _____ DATE: _____

OFFICE POLICIES

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 MAY IMPOSE AN INTEREST CHARGE OF (20% APR) ON BALANCES OVER 60 DAYS.

I AM AWARE THAT I MAY BE CHARGED A $50.00 FEE FOR MISSED APPOINTMENTS, IF I DO NOT NOTIFY BRICK WOMEN'S PHYSICIANS AT LEAST 48 HOURS PRIOR TO MY NEXT SCHEDULED APPOINTMENT.

ROUTINE YEARLY GYNECOLOGICAL EXAMS CONSISTS OF: PAP SMEAR, BREAST EXAM, PELVIC EXAM, AND (FOR WOMEN OVER 50) A FECAL OCCULT TEST. I MAY BE RESPONSIBLE FOR A COPAY AND/OR DEDUCTIBLE FOR PROBLEMS ADDRESSED OUTSIDE THE SCOPE OF A YEARLY EXAM.

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 HAVE READ THE OFFICE POLICES STATED ABOVE:

_____ _____

SIGNATURE DATE

ACKNOWLEDGMENT 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 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

REVISED 05/09/2018