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

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

SECONDARY INSURANCE

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

PLEASE READ AND INITIAL THE FOLLOWING

ROUTINE YEARLY GYNECOLOGICAL EXAMS CONSISTS OF: PAP SMEAR, BREAST EXAM, PELVIC EXAM, AND (FOR WOMEN OVER 50) FECAL OCCULT TEST. IF YOU DISCUSS ANY OTHER ISSUES OUTSIDE OF THE ROUTINE GYN EXAM, YOU WILL BE LIABLE FOR A COPAY AND/OR DEDUCTIBLE. _____

IF YOU ARE A NEW PATIENT WITH A PROBLEM, YOU MAY NOT BE ABLE TO HAVE YOUR ROUTINE YEARLY GYNECOLOGICAL EXAM ON THE SAME DAY. _____

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 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

REVISED 12/201