Flagship Office/ Corporate Office
555 Passaic Ave. Suite 10,
New Jersey, NJ 07006
P 973-227-0680| **F** 973-227-0736

REGISTRATION UPDATE/AOB

Date_______________Home Phone_____________________Work Phone_________________Email_________________________

Patient Last Name_________________________First Name_______________________Sex ❐M ❐ F Birth date_______________

Street Address____

❐ Single ❐ Married ❐Widowed ❐Separated ❐ Divorced Social Security #____

Relationship to Insured ❐ Self ❐Spouse ❐Other Insured Name______________________________DOS:_____________

EMPLOYER	Company Name____Occupation___________________ Address_____________________________________Phone_______________ ❐ Full-time ❐ Part-time City__________________________State______________Zip__________Years Employed_______________
PATIENT INSURANCE INFORMATION	Please list any and all insurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ❐ BCBS ❐ Aetna ❐ UHC ❐ Oxford ❐ GHI ❐ Other: ____ Policy/Group #:_______________________________________Effective Date:__________________________ Name of Insured:_______________________________________ID #:_______________________________
SPOUSE COINSURANCE INFORMATION	Please list any and all coinsurance and/or employee health care plan coverage you or your spouse may have Insurance Company or Health Care Plan Name ❐ BCBS ❐ Aetna ❐ UHC ❐ Oxford ❐ GHI ❐ Other: ____ Policy/Group #:_______________________________________Effective Date:__________________________ Name of Insured:_______________________________________ID #:_______________________________
Patient Agreement & Authorization For The Release Of Medical And Health Plan Documents For The Claims Processing & Reimbursement As Required by Federal and State Laws	**Legal Assignment Of Benefits And Designation Of Authorized Representative** In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign and convey directly to the above named healthcare provider(s), as my designated Authorized Representative(s), all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such provider(s), regardless of such provider's managed care network participation status. I understand and agree that I am legally responsible for any and all actual total charges expressly authorized by me regardless of any applicable insurance or benefit payments. I hereby authorize the above named provider(s) to release all medical information necessary to process my claims under HIPAA. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such provider(s) any and all plan documents, insurance policy and/or settlement information upon written request from such provider(s) in order to claim such medical benefits, reimbursement or any applicable remedies. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions. I hereby convey to the above named provider(s), to the full extent permissible under the laws, including but not limited to, ERISA §502(a)(1)(B) and §502(a)(3), under any applicable employee group health plan(s), insurance policies or public policies, any benefit claim, liability or tort claim, chose in action, appropriate equitable relief, surcharge remedy or other right I may have to such group health plans, health insurance issuers or tortfeasor insurer(s), with respect to any and all medical expenses legally incurred as a result of the medical services I received from the above named provider(s), and to the full extent permissible under the laws to claim or lien such medical benefits, settlement, insurance reimbursement and any applicable remedies, including, but are not limited to, (1) obtaining information about the claim to the same extent as the assignor; (2) submitting evidence; (3) making statements about facts or law; (4) making any request, or giving, or receiving any notice about appeal proceedings; and (5) any administrative and judicial actions by such provider(s) to pursue such claim, chose in action or right against any liable party or employee group health plan(s), including, if necessary, bring suit by such provider(s) against any such liable party or employee group health plan in my name with derivative standing but at such provider(s) expenses. Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal or state laws. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement. ____ ___________________________ Signature of Member of Legal Guardian/Representative Date

Revised 12/13/2022