CITY SURGICAL CARE

Flagship Office / Corporate Office:
555 Passaic Ave. Suite10
West Caldwell, NJ 07006
P 973-227-0680 | **F** 973-227-0736

PATIENT DEMOGRAPHICS

Patient Name _____ DOB _____ MRN _____

Home Address _____ Telephone (indicate primary with a " * ")

_____ (H) _____

_____ (C) _____

Email _____ (W) _____

Pharmacy Name _____ Marital Status ❒Single ❒Married ❒Widowed ❒Separated

Telephone _____ Emergency Contact _____

Address _____ Telephone _____

Relationship

INSURANCE WAIVER

I, _____ am scheduled to be seen by _____ on _____
PATIENT NAME PROVIDER'S NAME VISIT DATE

❒ I am not covered by insurance, I acknowledge it is my responsibility to pay associated charges

❒ My current insurance plan is _____, _____ that I believe should cover the planned services
INSURANCE NAME MEMBER ID#

Insurance Subscriber: ☐ Self or; _____ Relationship: _____ DOB: _____
NAME OF INSURANCE SUBSCRIBER

I understand that if any of the following apply, all charges incurred today will be my responsibility:

- If I do not have insurance coverage
- Until I provide current, correct insurance information before my insurance plan's filing limit expires
- Unless all my obligations to ensure reimbursement by my insurance plan are met, this includes but is not limited to meeting my health plan's requirement(s) for my physician to be paid.
- If I choose to receive services more often than what will be reimbursed by insurance

I am aware and agree to be fully responsible for payment of all associated charges under the stated conditions

PATIENT SIGNATURE DATE

Under HIPAA Privacy Regulations, a patient may allow access to his/her Protected Health Information (PHI)

❒ I DO NOT WANT information discussed with anyone.

❒ I hereby give permission to Dr. _____ to discuss: ❒ Test/Lab Results ❒ Entire Medical Record

❒ Make/Cancel Appointments with; _____ / _____
PERSONS NAME / RELATIONSHIP

Notice of Privacy: ❒ Received ❒ Refused _____ _____
SIGNATURE DATE

AUTHORIZATION OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I authorize the release of my medical information for purposes of treatment, payment and healthcare operations. Additionally, I authorize and assign any payment of medical benefits to City Surgical Care of New Jersey (the "Practice") its successors and assigns, or any individual it may designate for services provided. As part of this authorization, "the Practice" will release HIV, Drug and Alcohol, and Mental Health/Psychiatric information as required by law unless otherwise indicated. I understand that I have the right to request that services for which I have paid out-of-pocket, not be disclosed to my health plan. I agree to pay interest at the prevailing rate for amounts 30 days past due, as well as costs including attorney's fees, associated with the collection of any amounts due, for services rendered. I understand that I am financially responsible to "the Practice", its successors and assigns or any individual it may designate, for amounts owed by me in accordance with my health benefits coverage. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered

SIGNATURE OF PATIENT OR PARENT OF MINOR DATE