PATIENT INFORMATION

Patient Name: (Last) _____ (First) _____ **(MI)** _____

DOB: _____ **SSN:** _____ **Sex:** Male ○ Female ○

Address: _____ **City:** _____ **State:** _____

Zip: _____ **Marital Status:** _____ **Primary Doctor:** _____

Phone #: (Home) _____ (Cell): _____

Email ID: _____

Race: Caucasian ○ African American ○ Asian ○ Hispanic or Latino ○

Ethnicity: _____ **Nationality:** _____

Pharmacy: _____

Obtain Medication History from Pharmacy: Yes ○ No ○

Employment Status: Full Time ○ Part Time ○ Retired ○ Not Employed ○

Student Status: Full Time ○ Part Time ○ Not a Student ○

Advance Directives: Living Will ○ Power Of Attorney ○ **Declined** ○

A legal guardian or health care proxy: _____ **Declined** ○

Do you have any Impairment? _____

Do you smoke? If yes, how many per day do you smoke? _____

Do you drink alcohol beverages? If yes, type & how often? _____

Do you use street drugs? If yes, type & how often? _____

INSURANCE INFORMATION

Primary Insurance Company: _____

Insured Name: (Last) _____ (First) _____ (MI) _____

Address: _____ **DOB:** _____ **SSN:** _____

City: _____ **State:** _____ **Zip:** _____ **Marital Status:** _____

Identification#: _____ **Group #:** _____

Relationship to Patient: _____

Secondary Insurance Company:

Insured Name: (Last)_____ (First) _____ (MI) _____

Address: _____ **DOB:** _____ **SSN:** _____

City: _____ **State:** _____ **Zip:** _____ **Marital Status:** _____

Identification#: _____ **Group #:** _____

Relationship to Patient: _____

I authorize release of any information necessary to process my insurance claims. I assign and request payment directly to physician(s). HIPPA NOTICE OF PRIVACY PRACTICES ACKNOWLEDGED.

Signature: _____ Date: _____

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Information to be used or Disclosed. The information covered by this authorization includes: any/ or all information concerning my medical condition and treatment, including copies of applicable hospital and medical records, to Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Name of person or organization Relationship

Name of person or organization Relationship

_____ _____

Cell phone number alternate number

If we cannot reach you at above number, Ansonya Family Care may contact you (including leaving messages) regarding appointments or lab results _____yes _____no

If no, may we contact you via mail _____yes _____no

Expiration Date of Authorization: This authorization is effective unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to ANSONYA FAMILY CARE.

Potential for Re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Name of Patient

Signature of Patient Date

Ansonya Family Care
238 Ernston Road
Parlin, NJ 08859
Phone 732-727-5110
Fax 732-316-2323
Email: staff@ansonya.com

Financial Policy

We welcome you to Ansonya Family Care. The following is a statement of our financial policy. All patients must complete our patient information forms before seeing the doctor.
Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment may be made by cash, MasterCard, Visa and Discover. We will only bill insurance carriers with whom we are in-network (have signed a contract with). New Patient is responsible to provide us your primary and secondary insurance card(s) at the time of your appointment. Existing patient is responsible for updating change(s), if any, in address, phone number and insurance carrier information. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance requires copay, it must be paid **at the time** of the appointment. **All deductibles and outstanding balances are also due at the time of your visit.**

Regarding Managed Care/HMO insurance with which we participate. If patient Managed Care/HMO insurance plan requires election of primary care physician (PCP), patient is responsible for choosing a PCP from Ansonya Family Care. If you don't elect Ansonya Family Care as a PCP when your insurance plan requires, patient will be required to pay for the full visit.

Regarding Non-participating Insurances; if we don't participate with your insurance, the bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

We do participate with Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one or to you. Patient having Medicare will also be responsible for payment of yearly deductible.

Returned check fee-$25.00. Our Bank charges us a fee for any check that is returned for "insufficient funds" and this will be added to the patient's bill if this happens.

If you are unable to keep a scheduled appointment, 24 hours' notice of cancellation is required. Otherwise a $25.00 charge will be made for the time that was reserved to you.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process**. Accounts that go to collection will be subject to additional 35% charge.**

Thank you for your cooperation in understanding our financial policy. Our practice is committed to provide highest quality of treatment to our patients, and we charge what is usual and customary for our area. If you can't pay in full at the time of service, please let us know to discuss a payment plan.

I have read the above Ansonya Family Care Financial policy. I understand and agree to abide by its terms.

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Signature of Patient/Parent/Guardian Date

Ansonya Family Care
238 Ernston Road
Parlin, NJ 08859-1947
Phone: (732) 727-5110
Fax: (732)316-2323
Email: staff@ansonya.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Re: _____

Patient's Name (Print)/ Date of Birth

_____
_____
_____
Chart # _____

___ Release records **TO** Ansonya family Care from: _____
___ Release records **FROM** Ansonya Family Care to: _____

Doctor or Medical Center (Print)

_____

Address:

_____
_____

Areas of specific interest or concern:

All _____ Illness/Hospitalizations _____
Immunizations ____ Lab/Consultations _____

I authorize you to furnish a copy or summary of medical records of the above named patient to the above named doctor/ medical facility. I release you from all legal responsibility or liability that may derive from this authorization.

Signature: _____ Date: _____