Stafford Medical, P.A.

1364 Route 72 West
Manahawkin, NJ 08050

NAME_____ DOB_____ AGE_____ SEX_____
SOCIAL SECURITY #_____ PHONE NUMBER_____
ADDRESS_____
CITY_____ STATE_____ ZIP_____
MARITAL STATUS_____ IF MARRIED THEN SPOUSE'S NAME_____
EMPLOYED: Y / N EMPLOYERS NAME & PHONE_____
EMPLOYERS ADDRESS_____
PRIMARY INSURANCE_____ POLICY #_____
ADDRESS & PHONE_____
SECONDARY INSURANCE_____ POLICY #_____
ADDRESS & PHONE_____
(IF OTHER THAN SELF) POLICY HOLDER'S NAME_____
RELATIONSHIP TO PT_____SSN_____EMPLOYER_____
(IF MINOR PT) PERSON RESPONSIBLE _____ REL TO PT _____
OTHER FINANCIAL INFORMATION _____

CONSENT TO DISCLOSURE OF MEDICAL INFORMATION: I hereby, consent to, and authorize Stafford Medical, P.A. to disclose to any person, agency or company who may be required to pay all or part of medical costs, information from my medical record relating to my identity, diagnosis, prognosis, or treatment. I understand that the specific type of information which may be disclosed may include diagnosis, history and physical, progress notes, nurse's notes, doctor's orders, test results, consultations, and emergency treatment information. The purpose or need for this disclosure is to enable Stafford Medical, P.A. to secure payment for my bill or to provide other medical providers with information which may contribute to my overall medical care. I understand this consent shall operate as a complete release of liability to Stafford Medical, P.A. and its employees for the release of my information authorized by this form.

ASSIGNMENT OF BENEFITS

MEDICARE: I authorize Stafford Medical, P.A. to release to the Social Security Administration of its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment on the Medicare claim form.

OTHER INSURANCE CARRIERS: I hereby authorize payment directly to Stafford Medical, P.A. the insurance benefits which would usually be payable to me, as partial or complete payment for services rendered to me. Stafford Medical, P.A. will bill the responsible party $10, in addition to the copay, if it is not paid in full at the time of service. I agree to be responsible for payment of any charges not covered or paid by my insurance.

SIGNATURE OF PATIENT_____DATE_____

SIGNATURE OF INSURED (IF OTHER THAN PATIENT)_____

FINANCIAL POLICY

IT IS THE POLICY OF STAFFORD MEDICAL THAT PAYMENT IS TO BE MADE AT THE TIME SERVICES ARE RENDERED. IF THIS SHOULD CREATE A FINANCIAL HARDSHIP, PLEASE NOTIFY THE BUSINESS OFFICE PRIOR TO SEEING THE DOCTOR SO THAT PAYMENT ARRANGEMENTS CAN BE MADE. IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE, YOUR INITIAL OFFICE VISIT MUST BE PAID IN CASH OR CREDIT/DEBIT CARD.

INSURED PATIENTS: WE WILL GLADLY ACCEPT MOST INSURANCE. IF YOU HAVE A COPAY, PAYMENT IS EXPECTED AT THE TIME OF SERVICE. IF YOU DO NOT PAY THE COPAY AN ADDITIONAL $10 WILL BE ADDED TO THE COPAY AND THE RESPONSIBLE PARTY WILL BE BILLED. ALL INSURANCES WILL BE SUBMITTED. HOWEVER, IF YOUR INSURANCE DOES NOT COVER THE VISIT OR ONLY PAYS A PERCENTAGE, YOU ARE LIABLE TO PAY THE BALANCE. ALL BALANCES ARE DUE WITHIN 30 DAYS. INSURANCES WITH A PRIMARY CARE PHYSICIAN'S NAME OR NUMBER ON THE CARD WILL NOT BE ABLE TO BE SUBMITTED AND YOU ARE LIABLE FOR PAYMENT AT THE TIME OF SERVICE.

MEDICARE PATIENTS: STAFFORD MEDICAL IS PARTICIPATING WITH MEDICARE. WE DO ACCEPT ASSIGNMENT ON ALL CLAIMS. ONCE MEDICARE HAS MADE PAYMENT, YOU WILL BE BILLED FOR THE REMAINING 20% BALANCE WHICH IS DUE AND PAYABLE.

MINORS: A CUSTODIAL PARENT IS EXPECTED TO PAY AT THE TIME SERVICES ARE RENDERED. WE ARE UNABLE TO ACT AS MEDIATORS IN FINANCIAL MATTERS OF THIS NATURE. IN ORDER FOR US TO SEE A MINOR PATIENT, WE MUST HAVE A NOTE DATED AND SIGNED BY A PARENT.

WORKER'S COMPENSATION: WE PARTICIPATE WITH WORKER'S COMPENSATION AS LONG AS WE HAVE AN AUTHORIZATION FROM THE COMPANY/OWNER ALONG WITH THE CORRECT BILLING ADDRESS AND PHONE NUMBER.

DELINQUENT ACCOUNTS: BALANCES OVER 90 DAYS WILL BE TURNED OVER TO A COLLECTION AGENCY.

A COPY OF OUR FINANCIAL POLICY IS AVAILABLE UPON REQUEST.

I HAVE READ AND UNDERSTAND THE ABOVE POLICY.

NAME (PRINT):_____

SIGNATURE:_____ DATE:_____