URGI-MED URGENT CARE OF RANDOLPH
FAMILY MEDICINE W.
DEDICATION AND COMPASSION
400 RT 10 WEST
RANDOLPH, NJ 07869
TEL: 973-891-1321
FAX: 973-206-5049

PATIENT REGISTRATION PACKET

GENERAL INFORMATION

Last Name: _____
First Name: _____
DOB: _____
SSN: _____
Gender: _____
Marital Status: _____
Race: _____
Ethnicity: _____
Preferred Language: _____
Pharmacy: _____

ADDRESS & CONTACT INFORMATION

Street Address: _____
_____
City: _____
State: _____
Zip Code: _____
Home Phone #: _____
Cell Phone #: _____
Work Phone #: _____
Email Address: _____
Emergency Contact: _____
Relationship: _____
Phone Number: _____
Reason for visit today: _____

INSURANCE INFORMATION

Primary Insurance

Company Name: _____
Policy Number: _____
Group Number: _____
Policy Holder's Name/DOB: _____

Secondary Insurance

Company Name: _____
Policy Number: _____
Group Number: _____
Policy/Name/DOB: _____

How did you find us?

Please circle

1) Internet 2) Sign/Drive By
3) Direct Mail 4) Referred

If referred please provide us their name, so we can thank them!_____

ASSIGNMENT OF INSURANCE BENEFITS

I herby authorize direct payment of surgical/medical benefits to Dr._____ for services rendered by him/her in person or under his/her supervision. I understand that I am financially responsible for any balance not covered by my insurance.

MEDICARE/MEDICAID

I certify that the information given by me in applying for payment is correct. I request that payment of authorized benefits be made on my behalf.

HIPPA PRVACY PRACTICE

I acknowledge that I received and/or have been given the opportunity to review this office's notice of HIPPA Privacy Practices for protected health information
A photocopy of these assignments shall be valid as the original.

_____
Patient/Guardian Signature & Date

C- SHEET

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HEALTH QUESTIONAIRE

REASON FOR YOUR VISIT TODAY _____

PATIENT NAME _____

PATIENT DOB _____

HOW LONG HAVE THESE SYMPTOMS BEEN PRESENT FOR?
_____

ANY MEDICATIONS TAKEN CURRENTLY? YES/NO
IF YES PLEASE EXPLAIN _____

INITIALS____ DATE___/___/____

URGI-MED URGENT CARE of RANDOLPH

COMMUNICATION CONSENT

It is the office policy of Urgi-Med and its staff not to release confidential and/or unauthorized information by any means (home phone, answering machine, work phone, voice mail, etc.). Whenever returning telephone calls we do not leave or release information by any means unless specified by the patient.

I _____ authorize the Urgi-Med staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Contact Method	Yes	No	Number
Home Phone			
Cell Phone			
E-Mail			
Fax medical records/referrals to another entity			
May we leave a voicemail? Please specify where.			
Detailed voicemail			
Name and Number only			

Would you like information to be released to someone other than yourself? If so, please complete the following:

Individuals' Name _____

Ph. # _____

Individuals' Name _____

Ph. # _____

Print Name _____

Signature _____

Date _____

URGI-MED URGENT CARE of RANDOLPH

INSURANCE/PAYMENT POLICY

URGI-MED will submit claims to certain insurance companies for services rendered. Our office makes no representation that we participate with your particular insurance plan. If you have any questions regarding details and/or restrictions of your plan, you must contact your insurance carrier directly. Outlined below are our policies with regard to payment for services rendered.

- All co-payments, co-insurances, and deductibles are due at time of service. Although we may participate with your insurance carrier, we may not participate with your particular plan.
- If you are here for a motor vehicle accident and your auto insurance is your primary insurance, you must pay in full at the time of service.
- If a claim is submitted on your behalf, you will be balance-billed for all non-covered services, co-insurances and deductibles.
- Payment is due within fifteen (15) days of receipt of a bill.
- Balances not paid within fifteen days will be subject to a $7.00 rebilling charge and any additional costs associated with collections. Additional collections costs can include: Certified Letter fee of $ 15.00; Court Preparation fee of $15.00; Court Service fee of $22.00 and fees from a Third Party Collection Service (may be up to 50%) as assessed by said company. Customary attorney fees atd interest charges will be added to your bill if your account is sent to collections.
- A fee of $30.00 will be assessed for all returned checks.
- A fee may be assessed for copies of medical records.
- A fee of $25.00 may be assessed for any appointment not cancelled within 24 hours.
- Non-covered services. Please be aware that some and perhaps all of the services you receive may be non covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

It is the patient's responsibility to obtain referrals in advance of scheduling appointments with specialists if their plan requires one. Requests for referrals will be reviewed by a physician and the patient will be notified within five (5) business days of the status of the request. URGI-MED is not permitted to issue back-dated referrals.

I hereby authorize my insurance carrier to release payment directly to URGI-MED for medical services provided to me. I also authorize release of any medicals records of information required to determine benefits for payment of medical services.

I have read and understand the payment policy and agree to abide by its guidelines:

Print Name_____

Signature_____

Date_____