



115 Christopher Columbus Drive
Suite 301
Jersey City, New Jersey 07302
201-706-3808

<http://www.drsmedicalassociates.com/>

WELCOME TO DRS MEDICAL ASSOCIATES LLC! PLEASE COMPLETE THE FORM LEGIBLY AND ENTER AS MUCH INFORMATION AS YOU CAN!

Today's Date: _____

PATIENT'S Last Name: _____ **First** _____ **Middle:** _____
Birth date _____

Parent 1 Last Name: _____ **First** _____ **Middle:** _____

Cell Phone _____
Street Address _____

City _____ State _____ Zip _____

Home Phone _____

Birth date _____ Soc Sec # _____

Employer _____ Occupation _____

Yrs. Employed _____ Work Phone _____

Ethnicity: _____ Language Spoken: _____

Email Address: _____

Parent 2 Last Name: _____ **First** _____ **Middle:** _____

Cell Phone _____

Street Address _____

City _____ State _____ Zip _____

Home Phone _____

Birth date _____ Soc Sec # _____

Employer _____ Occupation _____

Yrs. Employed _____ Work Phone _____

Ethnicity: _____ Language Spoken: _____

Email Address: _____

1) STANDARD INSURANCE INFORMATION:

NAME of POLICY HOLDER: _____

Effective Date of Coverage _____

NAME OF INSURANCE COMPANY: _____

Claims Mailing Address: _____

City: _____

State/Zip: _____

Address Associated with Insurance Policy: _____

INSURED'S ID # _____ GROUP # _____ DEDUCTIBLE AMT _____

COPAY: _____

ALL CHILDREN'S NAMES / DATES OF BIRTH	STANDARD	INS	PLAN	NAME /	ID#
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

NEAREST RELATIVE: Name: _____ Relation: _____

Phone: _____

Address: _____

AUTHORIZATION FOR VERIFICATION OF INFORMATION: I certify that to the best of my knowledge the statements contained herein are true. I authorize DRS MEDICAL ASSOCIATES LLC and/or its assignee to verify statements made herein.

RELEASE OF MEDICAL INFORMATION: I hereby authorize DRS Medical Associates LLC to release medical information relating to my condition as appropriate to all parties as deemed appropriate by DRS Medical Associates. I authorize the release of any medical information necessary to process claims for insurance reimbursement or payment. I further authorize payment to DRS Medical Associates LLC of any medical benefits resulting from medical or surgical services rendered by DRS Medical Associates LLC.

FINANCIAL RESPONSIBILITY: I agree to be responsible for all claims and charges incurred by any of the above named children. I understand that DRS Medical Associates LLC will bill the insurance company and will be reimbursed for the services rendered to any of the above named children. I agree and understand that I will be expected to pay for services

at the time of each visit. I further agree to pay all collective costs, responsible attorney fees, and other costs that may be incurred to enforce collection of any amounts outstanding. If any payment(s)/explanation of benefits are issued directly to me for care received at DRS Medical Associates LLC, I shall forward such payment(s)/explanation of benefits to DRS Medical Associates LLC for posting in a timely fashion. In cases of claims being submitted to the insurance carrier, it is my responsibility to financially cover any deductibles, co-payments, co-insurance and non-covered services as stipulated by my specific insurance plan.

MISSED APPOINTMENTS: I understand and acknowledge that DRS Medical Associates LLC maintains the right to directly charge me (as well as every other patient, except Medicaid patients) a No Show fee in the amount of \$75.00 if I do not show for my scheduled appointment and/or did not provide DRS Medical Associates LLC with at least 24 hours notification prior to my appointment about cancelling or rescheduling my appointment. If the No Show fee is charged, I agree that I shall promptly make such payment to DRS Medical Associates LLC. In case of any cancellation, I will use my best effort to re-schedule such cancelled visit within 1 to 2 weeks.

FOR EMERGENCY CARE: I authorize the performance of any necessary medical and surgical treatment of my children in case of illness or accident when neither parent (nor guardian) can be located. The medical and surgical services required may be performed by the physicians of DRS Medical Associates LLC or a licensed physician of their choice, at the medical facility, office, emergency room or hospital of their choice.

Signature of Parent/Guardian

Date

Printed name of Parent/Guardian

Relationship to the patient