BERGEN
MEDICAL ASSOCIATES
A Premier Medical Alliance Partner

PATIENT REGISTRATION

Patient Number:

Date: 03/04/2016 **DOB:** MM/DD/YYYY

Name: FULL NAME **Street:**

City: **State:**

Zip: **Home:** **Preferred:** ☐

Email: **Cell:** **Preferred:** ☐

SS: **Work:** **Preferred:** ☐

Please select one

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Permission to text appointment reminders

Sex: ☐ Male ☐ Female ☐ Other

Race: ☐ White ☐ Asian ☐ American Indian ☐ African American ☐ Other ☐ Refuse

Ethnicity: ☐ White ☐ Hispanic ☐ Non-Hispanic ☐ Refuse

Primary Language: ☐ English ☐ Spanish ☐ Other ☐ Refuse

Local Pharmacy: **Phone:**

Street: **City:** **State:**

Mail Away Pharmacy: **Phone:**

Street: **City:** **State:**

Emergency Contact: **Patient's Relation to contact:** **Phone:**

Referring Physician: **City:** **Phone:**

Primary Physician: **City:** **Phone:**

Employment Information

Employer: _____ **Phone:** _____

Street: _____ **City:** _____ **State:** _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** MM/DD/YYYY

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

Secondary Insurance: _____

Policy Number: _____ **Group Number:** _____

Street: _____

City: _____ **State:** _____ **ZIP:** _____

Subscriber: _____ **Phone:** _____ **DOB:** MM/DD/YYYY

Street: _____ **Relationship to patient:** _____

City: _____ **State:** _____ **Zip:** _____

Does your current policy require a referral? ☐ Yes ☐ No

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS (ALL NON-MEDICARE INSURANCE PLANS)

To assist in the processing of my insurance claim, kindly furnish my insurance company with any information you may have regarding my condition while under your treatment. I authorize payment of benefits directly to Premier Medical Alliance LLC, for service described. I accept full financial responsibility for services rendered. I authorize payment of medical benefits to the physician for services rendered.

Signature: _____ **Date:** _____

ASSIGNMENT OF BENEFITS (MEDICARE AND/OR MEDICAID)

I authorize any holder of medical or other information about me to release to the Social Security Administration and The Health Care Financing Administration or their intermediaries or carriers, or the billing agent of this Physician, 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 this assignment.

Signature: _____ **Date:** _____

Consent of Financial Liability:

Welcome to Premier Medical Alliance LLC. We are pleased you have chosen us for your medical care. We are committed to providing you with the highest quality services available. Please read and sign the following policy. If we are contracted with your insurance company we will accept assignment. All co-pays are due at time of service. All co-insurance and deductibles will be due at time of service depending on our contract with your insurance company. All other patient responsibility will be billed to you accordingly. You are expected to understand your benefit coverage and financial responsibility. Failure to provide up to date accurate insurance and billing information or referrals if applicable will result in all charges for services to be the sole responsibility of the patient/guarantor. If we do not have a contractual obligation with your insurance company, you are responsible for 100% of the payment at time of service.

I understand my financial responsibility:

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, FULL NAME _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

Patient's Number: _____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) _____

****You May Refuse to Sign This Acknowledgement****

MEDICAL INFORMATION RELEASE FORM
(HIPAA RELEASE NOTICE)

Name: FULL NAME **DOB**: MM/DD/YYYY

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Name	Relationship	DOB	Phone Number
		MM/DD/YYYY	
		MM/DD/YYYY	
		MM/DD/YYYY	
		MM/DD/YYYY	
		MM/DD/YYYY	

☐ Information is not to be released to anyone

This **Release Of Information** will remain in effect until terminated by me in writing

By signing this form you are acknowledging the release of information to all partners of Premier Medical Alliance, except our Gynecology office. You will be required to sign a second release form when seeing our gynecologists.

Signature: _____ Date: _____

Witness: _____ Date: _____