1567 Palisade Avenue 1st Floor
Fort Lee, New Jersey 07024

PATIENT REGISTRATION FORM

Patient Name: Med. Rec.#: Today's Date:

Date of Birth: Age: S.S.#: Sex: M / F

Street Address: City: State:

Zip Code: Telephone: Cellular:

E-Mail: Referred By:

(EMPLOYER'S INFORMATION)

Occupation: Employer: Telephone:

Address: City: State: Zip Code:

(SPOUSE'S INFORMATION)

Spouse: Date of Birth: Age:

(SPOUSE'S EMPLOYER'S INFORMATION)

Occupation: S.S.#:

Employer: Telephone:

Street: City: State: Zip Code:

Primary Insurance: I.D#: Group#:

Insured Name: Telephone#: Relationship to Insured:

Secondary Insurance: I.D#: Group#:

Insured Name: Telephone#: Relationship to Insured:

In case of Emergency, contact:

WORK)

Relationship: Home: Work:

I certify that the information given by me is correct. All information shared in this treatment is confidential except in circumstances governed by law (in accordance to HIPAA regulations). If you would like us to confer with another healthcare professional, you will need to sign a "Release of Information" form. I can revoke this permission at any time. I request that payment of authorized benefit be made directly to Palisade Surgery Center, LLC, for medical services rendered by the facility. I understand that I am financially responsible for any balance not covered by my health insurance.

Signature:_____ Date:_____

(NOTICE OF PRIVACY PRACTICE-HIPAA)

PALISADE SURGERY CENTER, LLC.

PATIENT ACKNOWLEDGEMENT & INFORMED CONSENT

I acknowledge receipt and review of a copy of this Notice, and my understanding and my agreement to its terms. I have been offered a copy of this document to take home upon my request.
I authorize the release to my insurance carrier of any medical information necessary to process claims or necessary lab work. I also authorize release of my pathology results to the facility utilizing all methods of transmission according to HIPAA regulations.

Signature:_____

FINANCIAL POLICY

Your payment is to be paid in full at the time of each session.
I hereby instruct and direct my insurance company to pay by check made out and mailed to Palisade Surgery Center, LLC., for the professional and medical expense benefits allowable, and otherwise payable to me under current insurance policy as payment toward the total charges for the medical services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to Palisade Surgery Center, LLC., and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. A photocopy of this Agreement shall be considered as effective and valid as the original.
I authorize Palisade Surgery Center, LLC., and staff to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Signature: _____

INSURANCE REIMBURSEMENT AGREEMENT AND DISCLAIMER

I hereby certify that I understand there will be medical claims submitted to my Health Insurance Company on my behalf. These claims may represent services provided by the Palisade Surgery Center, LLC., and/or the anesthesiologist. These insurance claims are independent of any out of pocket payments made by me, and I understand that I am not to keep moneys paid by third party insurance carriers billed for these purposes.
I further understand that the facility is not a participating provider with my insurance carrier and that reimbursement checks may be sent to me. I agree to forward any such payments upon receipt. I further agree that I am financially responsible for the full amount billed by any or all of the above parties plus 1.5% interest starting 30 days from documented receipt of such payments by me.
I will be responsible for the difference between the reimbursement and the doctor's surgical fee, if any, as well as co-payments and deductibles. I will keep in mind that depending upon the type of coverage my insurance carrier may or may not acknowledge the claim fully or at **all**. The facility is not responsible for any partial and/or denied reimbursement from my insurance.

Patient's Name: Date:

Patient's Signature:

Witness Signature: