PATIENT INFORMATION FORM
PRINT CLEARLY

Name:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Email Address:_____

Home Address:_____ City_____ State:____ Zip Code:_____

Social Security #:_____ Date of Birth:_____

Insurance Name:_____ _Policy#_____

Insured: SELF SPOUSE CHILD OTHER Insured Name:_____

Primary Care or Referring Physician:_____ Phone:_____

Primary Care or Referring Physician address:_____

Whom may we thank for referring you to us?_____ Phone:_____

Whom may we contact in case of an emergency?_____ Phone:_____

Did you sustain an injury at work?
Y N

Are you covered under an employer or union policy?
Y N

Are your injuries accident related:
Y N

Are you currently employed?
Y N

Do you have a secondary insurance policy? If yes, please enter_____

I am a new patient to this practice and have I verifiable coverage with my insurance carrier? Y N

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered.. I have read all the information on this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____
Signature Date

MEDICARE PATIENT'S ONLY: Have you made any changes to your choice of Medicare options in the last open enrollment period? Y N

ASSIGNMENT OF BENEFITS FORM

Patient's Name:_____ Today's Date:_____

Insurance Name:_____ ID#:_____

I, _____, understand that services rendered to me by Dr. Joseph S. Fox & Associates
(Patient's Name)

are my financial responsibility and that the Provider will bill my insurance company,

_____as a courtesy. I authorize my insurance company to pay my benefits directly
(Name of Insurance)

to Dr. Joseph S. Fox & Associates and I understand that I will be fully responsible for any outstanding balance on my account.

I have been given the opportunity to pay my estimated deductible and co insurance at the time of service. I have chosen to assign the benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by _____.
Name of Insurance

I authorize the provider to release any information necessary to adjudicate the claim, and understand that there may be associated costs costs for providing information above and beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me, I will forward the payment to Dr. Joseph S. Fox & Associates within 48 hours. I agree that if I fail to send the payment to the Provider and they are forced to proceed with the collection process; I will be responsible for any cost incurred by the office to retrieve their monies.

To avoid this additional cost and inconvenience, should the insurance company forward payment to me, I authorize Dr. Joseph S. Fox & Associates to facilitate payment utilizing the credit card number on file to resolve the balance.

I authorize the provider to initiate a complaint to the insurance commissioner for any reason on my behalf and personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Signature of Policyholder Patient/Guardian Printed Name

Dear Patient:

Please take a few minutes to read the following. In today's constantly changing insurance regulations, this may apply to you.

1. **You may need a written authorization from your Primary Care Physician to be examined.**

2. **You may need a written authorization from your Primary Care Physician for all the follow up visits.**

   ****IT IS YOUR RESPONSIBILITY TO OBTAIN THIS AUTHORIZATION****
   ****YOU MUST BE AWARE OF THE NUMBER OF VISITS ALLOWED AND THE DATE OF EXPIRATION****

3. **You may need authorization from the Primary Care Physician, this office, or directly from your insurance company for surgery and laboratory work.**

We will do our best to try and help you comply with all these regulations. Please do not hesitate to ask.

I assign the benefits of my health insurance plan to Dr. Joseph S. Fox, Dr. Christopher Minacapilli, Dr. Jamie Seigal, Dr. Veena Mani and Dr. Scott Herbert as appropriate.

I have read and understand the above information.

_____ **Date** _____

Patient's or Authorized Person's Signature

Notice of Privacy Practices

Patient Acknowledgement

Patient Name:_____

Date of Birth:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy practices and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____

Date: _____

Relationship to patient (if signed by a personal representative patient)