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Insurance Information

Primary Insurance:

Name of Insurance:_____ Address:_____
Id#:_____ Group#:_____
Subscriber's name and date of birth: _____ SS#:_____
Subscriber's relationship to the patient: _____

Secondary Insurance:

Name of Insurance: _____ Address: _____
Id#:_____ Group#:_____
Subscriber's name and date of birth: _____ SS#:_____
Subscriber's relationship to the patient: _____

Tertiary Insurance:

Name of Insurance: _____ Address: _____
Id#:_____ Group#:_____
Subscriber's name and date of birth: _____ SS#:_____
Subscriber's relationship to the patient: _____

If the patient is a minor child please provide us with the name, address and phone number of the person with whom the child resides:

_____
_____
_____

NJ CEED PATIENTS ONLY:
Do you have a voucher: **Yes** or **No?**
Is it signed by both you and NJ Ceed representative: **Yes** or **No?**
This voucher will only cover the **initial office visit, the Colonoscopy and a single follow up visit only.**
Any subsequent visits after the first follow up or any other procedures done **will be the responsibility of the patient and will be due upon receipt of services, this will not be billed to you.**

Patient Signature: _____ Date: _____

No Insurance: I do NOT have insurance and will be paying all visits and procedures. All self-pay patients will need to bring payment in with them; payment is due upon receipt of services unless other arrangements have been made by management. If other arrangements are made and I default then I will be responsible for a **1.5%** monthly finance charge which will accrue on my balance due. If no payment is made **within 30 days** my account will be sent to collections with a **33% collection fee** or attorney fee added plus court costs as well.

Patient Signature: _____ Date: _____

Medicaid Patients: NJ Medicaid requires us to notify you prior to services that administrative costs such no show fees, medical record releases to yourself or any other administrative fees that our office **charges will not be covered by Medicaid and is the responsibility of the patient.**

Signature of Patient: _____ Date: _____

All Patients: Any deductible, co-insurance, co-payments **NOT** covered by your insurance is **your responsibility.** If your insurance denies your claim for anything other than coordination of benefits it is **your responsibility** to pay for the services. Should I fail to make my payments a **1.5%** finance charge will accrue and if payment is not made **within 30 days** it will be sent to collections with the **33% collection/attorney fee** added as well as any court costs associated.

Patient Signature: _____ Date: _____