vascular clinic
AT GARDEN STATE MEDICAL CENTER
DIAGNOSTIC LAB & TREATMENT

Kuldeep Singh, MD, RVPI | *Vascular & Endovascular Surgeon*

TEL: 732.202.3000 FAX: 732.849.0015

Welcome to our Practice

Please complete the attached forms and verify that all information is correct.

How did you hear about us? Please check all that apply.

☐ My Physician told me about you
☐ Friend, family or co-worker
☐ I saw your billboard
☐ Newspaper
☐ Clipper Magazine
☐ Valpak
☐ Website or Internet
☐ Other:_____

PATIENT INTAKE

Referral Reason			
Patient's Name		Date of Birth	Exam Date
Social Security Number	Gender ☐M ☐F	Home Phone	Cell Phone
Street Address, Apt		City, State, Zip Code	
Primary Care Physician	Referring Physician	Other	

PRIMARY INSURANCE INFORMATION

Insurance Company Name, Phone #		ID#	Group #
(If not Patient) Policy Holder's Name, Phone #		(If not Patient) Address, City, State, Zip	
Referral Required ☐Yes ☐No	Claim Address:	Pharmacy Name, Phone #	

SECONDARY INSURANCE INFORMATION

Insurance Company Name, Phone #		ID#	Group #
(If not Patient) Policy Holder's Name, Phone #		(If not Patient) Address, City, State, Zip	

ADDITIONAL DEMOGRAPHIC INFORMATION

Preferred Contact Method ☐ Home ☐ Cell	May We Leave a Message? ☐ Yes ☐ Cell	Marital Status ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widow	
Emergency Contact Name		Phone #	Relationship to Patient
Employment Status ☐Employed ☐Unemployed ☐Student ☐Retired ☐Military ☐Disability		Employer/School Name	
Race ☐American Indian or Alaska Native ☐Asian ☐Black or African American ☐White ☐Hispanic ☐Other Race ☐No Answer			
Ethnicity ☐Hispanic or Latino ☐Not Hispanic or Latino ☐No Answer		Spoken Language ☐English ☐Spanish ☐Other	Email Address

I hereby authorize Garden State Medical Center to furnish information to my insurance carriers concerning illness and treatment. I also authorize assignment of benefits to Garden State Medical Center to myself or my dependents. I understand that I am responsible for any amount that is not payable by my insurance company.

Patient's Name (Print)	Patient's Name (Signature)	Date

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Understanding Your Rights

ASSIGNMENT OF BENEFITS AND MY FINANCIAL RESPONSIBILITY

It is the policy of Garden State Medical Center to collect payment at the time of visit. If you have a policy with a company with which we have a contract, we will gladly file your claim for you. However, you are expected to pay any co-pay or deductible at the time of service. If we do not participate in your network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that I am responsible for any co-insurance fees/charges, if it is not covered by a secondary. I understand that my insurance company may send payments for the rendered services to me. I hereby assign to Garden State Medical Center all surgical, medical Insurance and other benefits, if any, otherwise payable to me for the services. If I receive direct payments from my insurance company, I agree to hold such payment(s) in trust for Garden State Medical Center and agree to endorse over and send such payment(s) to Garden State Medical Center within one week after receipt. I hereby authorize and direct payment directly to Garden State Medical Center from the obligor of said benefits. Further, I hereby assign and convey Garden State Medical Center, unless charges for the services have been paid, so much of any cause of action or right of recovery and any payment proceeds relating thereto, that I may have against any third party and direct my attorney, if one has been retained as well as any person to insurance company obligated to pay damages or restitution to me, to deduct the amount of any outstanding bill for Garden State Medical Center any settlement proceeds or other proceeds to be paid directly to me prior to receiving said proceeds. I understand that payment is due when services are rendered unless prior arrangements have been made. I assign all medical and/or surgical benefits including major medical benefits for services provided to Garden State Medical Center. This assignment will remain in effect until revoked by me in writing. I am aware that any charges NOT COVERED by my insurance policy are my responsibility. I further agree that, should my account with Garden State Medical Center be turned over for collection purposes, I will pay an attorney and collection fee equal to 33 1/3% of the outstanding balance, plus court costs and other fees incurred.

IDENTIFICATION PHOTOGRAPH AUTHORIZATION

Initals

I _____ give permission for Garden State Medical Center to take an identification photograph to be maintained in my medical records. I understand that this picture will be used in a confidential manner related only to my personal care in the above named office.

PRIVACY PRACTICES

I have received a copy of Garden State Medical Center Privacy Practices. I have had the opportunity to have any questions answered regarding the privacy practices of the doctor's office.

Patient/Guardian Signature	Date

Patient's Name (Print)	Patient's Name (Signature)	Date

Assignment of Benefits Form

Practice Name: Garden State Medical Center
Address: P.O. Box 397, Whiting, NJ 08759–0397
Phone: 732-849-0077

Patient's Name	
Social Security Number	Insurance ID Number
Insurance Claim Group	
Employer	

I hereby instruct and direct | Insurance Company | to pay by check made out and mailed to:

Garden State Medical Center
P.O. Box 397, Whiting, NJ 08759–0397

Or

If my current policy prohibits direct payment to Doctor, I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follows:

Patient Name
C/o Garden State Medical Center P.O. Box 397, Whiting, NJ 08759–0397

For the professional or healthcare expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, 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 Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Patient/Guardian Signature	Date
Witness	Date

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MEDICAL RECORDS RELEASE

I hereby authorize and request you to release to Advanced Endovascular & Vein Center the following medical information:

☐ Complete Records
☐ X-Rays
☐ Ultrasounds
☐ Biopsy Results
☐ Urological Related Records
☐ CT &/or MRI Scans
☐ Nuclear Scans
☐ Pathological Results

☐ All of the Above

Note: Special Dates of Interest: From _____ to _____

I understand that my express consent is required to release any health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health or drug or alcohol use. If I have been tested, diagnosed or treated for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders or mental health or drug or alcohol use, you are specifically authorized to release all health care information pertaining to such diagnosis, testing or treatment.

Patient's Name	Date of Birth	Social Security #
Street Address, Apt	City, State, Zip Code	

Patient's Name (Signature)	Date
Witness Name	Date

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Authorization to Appeal & File Legal Action

PATIENT'S INFORMATION

Patient's Name	
Insurance Company	Policy #

I hereby authorize Garden State Medical Center and its representatives to appeal any adverse benefit determinations by my insurance company. This includes my authorize for Garden State Medical Center to exercise any of my rights under my plan or under the law including my right to file legal action against my insurance company. As my designated authorized representative and as part of the appeal, I hereby authorize my insurance company in its decision letter and in connection with the processing of my appeal to communicate with **Garden State Medical Center and its representatives** in all aspects of the appeal.

I understand that these communications may contain the following:

All medical and financial information contained in my insurance file including but not limited to treatment for pain management relating to my examination, treatment and hospital confinement in connection with the determination which is being appealed.

I understand this information is privileged and confidential and will only be released as specified in this authorization, or as required or permitted by law. This authorization is valid for as long as I am under the care of the providers of Garden State Medical Center.

A photocopy of this authorization shall be considered effective and valid as the original.

Patient/Guardian Signature	Date
Witness	

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HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

This form will allow us to obtain any necessary medical information necessary to diagnose and treat the listed patient.

PATIENT'S INFORMATION

Patient's Name	Date of Birth	Social Security Number
Street Address	City, State Zip	

INFORMATION TO BE RELEASED:
This authorization includes release of information concerning treatment of psychiatric/ psychological conditions, drug and/or alcohol related conditions, and HIV or AIDS related conditions.

- ☐ Discharge summary
- ☐ History & Physical
- ☐ Face sheet
- ☐ Emergency Department Record
- ☐ Operative reports
- ☐ Pathology reports
- ☐ Laboratory reports
- ☐ Immunization/shot records
- ☐ Outpatient records
- ☐ Itemized bill
- ☐ Neuropsychological reports
- ☐ Psychological reports
- ☐ X-ray/Medical Imaging Report
- ☐ Entire medical record
- ☐ Other:_____

THE ABOVE INFORMATION IS TO BE RELEASE TO:
Garden State Medical Center
1100 Route 70 West
Whiting, NJ 08759

FOR THE PURPOSE OF:

- ☐ Continued medical care
- ☐ Personal interest
- ☐ Legal claim processing
- ☐ Insurance claim processing
- ☐ External quality/ utilization review
- ☐ Other:_____

Patient/Guardian Signature	Date
Patient Guardian/Authorized Representative	Relationship to Patient
Witness	