diagnostic imaging

AT GARDEN STATE MEDICAL CENTER

1314 Hooper Ave, Building B, Suite 101 | Toms River, NJ 08753

☎ (732) 202-3000 FAX (732) 849-0015 gsmedicalcenter.org

Welcome to our Practice

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

☐ My Physician told me about you ☐ Website or Internet ☐ Community event or seminar
☐ Insurance company ☐ Newspaper or magazine
☐ Friend, family or co-worker ☐ I saw your billboard ☐ Other:_____

PATIENT DEMOGRAPHIC INFORMATION			**Account #**	
Last Name / First Name		Date of Birth	Today's Date	
Social Security Number	Gender ☐Male ☐Female	Marital Status ☐Single ☐Married ☐Divorced ☐Widowed		
Street Address, Apt #		Home Phone	Preferred # ☐Home ☐Cell ☐Work	Leave Message ☐Yes ☐No
City, State, Zip Code		Cell Phone		
Emergency Contact Name		Phone #	Relationship to Patient	
Referring Physician Name, Phone #		Primary Care Physician Name, Phone #		
Employment Status ☐Employed ☐Unemployed ☐Student ☐Retired ☐Military ☐Disability		Employer/School Name, Phone #		
Race ☐White ☐Hispanic ☐Black or African American ☐Asian ☐Native American ☐Other Race ☐No Answer				
Spoken Language ☐English ☐Spanish ☐Other		Email Address		

PRIMARY INSURANCE INFORMATION			
Insurance Company Name, Phone #		ID#	Group #
Claims Address		Patient Relationship to Insured ☐Self ☐Spouse ☐Dependent	
Insured Name, Phone #	Insured DOB	Address	

SECONDARY INSURANCE INFORMATION			
Insurance Company Name, Phone #		ID#	Group #
Claims Address		Patient Relationship to Insured ☐Self ☐Spouse ☐Dependent	
Insured Name, Phone #	Insured DOB	Address	

IS THIS A WORKMAN'S COMPENSATION OR MOTOR VEHICLE CLAIM? ☐ Yes W.C. ☐ Yes P.I.P.		Date of Loss
Adjustor Name, Phone #	Company Name, Phone #	Claim #

Have you had any prior radiology studies? If so, where? _____

Please send a copy of my results to Dr. _____

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 your carrier is out of network, you are expected to pay at time of service, unless arrangements have been made with the financial advocate. I understand that my insurance company may send payments for the services rendered 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. I agree to endorse the check(s) over to Garden State Medical Center I understand that if I use the insurance proceeds for my personal use, I have committed Insurance fraud. 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 understand that should any account with Garden State Medical Center be turned over to a collection agency, I will be responsible for any additional interest on my outstanding balance or charges that may be incurred in the collection of my account.

PRIVACY PRACTICES

I have received a copy of the 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.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Garden State Medical Center and/or its designees to provide treatment and/or examination and release any information pertinent to my case in the course of my examination or treatment to my physician, insurance company, adjustor, or attorney, if applicable in this case.

Patient/Guardian/P.O.A. Signature	Date
Patient Name (Please Print)	

CONSENT FOR A MINOR FOR A DIAGNOSTIC IMAGING PROCDURE

The procedure has been explained in detail and I, as a legal guardian/parent of Patient Name

understand it and agree to it. I hereby give my informed consent for Procedure to be performed.

Patient/Guardian/P.O.A. Signature	Date

Assignment of Benefits Form

Practice Name: Garden State Medical Center
Address: 1314 Hooper Ave, Building B, Suite 101 - Toms River, NJ 08753 - Toms River, NJ 08753
Phone: 732-202-3000

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
1314 Hooper Ave, Building B, Suite 101
Toms River, NJ 08753

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
Garden State Medical Center 1314 Hooper Ave, Building B, Suite 101 Toms River, NJ 08753

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/P.O.A. Signature	Date
Witness	Date

HIPAA AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

INFORMATION TO BE RELEASED:

This form will allow us to obtain any necessary medical information needed to diagnose and treat the listed patient, including prior medical records and radiology reports.

PATIENT'S INFORMATION

Last Name	First Name	Date of Birth	Social Security Number
Street Address		City, State Zip	

THE ABOVE INFORMATION IS TO BE RELEASED TO:

Garden State Medical Center
1314 Hooper Ave, Building B, Suite 101
Toms River, NJ 08753
Fax: 732-575-1574

Patient/Guardian/P.O.A. Signature	Date
Guardian/P.O.A. Name (Please Print)	Relationship to Patient

MEDICAL RELEASE FORM

I grant my permission for Garden State Medical Center to speak with and/or release information regarding my medical treatment and/or condition to the following persons/medical offices:

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Name	Phone #
Street Address, Apt	Relationship to Patient
City, State, Zip Code	

Patient/Guardian/P.O.A. Signature	Date