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PRINCETON SPORTS & FAMILY MEDICINE

3131 Princeton Pike, Building 4A, Suite 100
Lawrenceville, NJ 08648
Phone: (609)896-9190 Fax: (609)-896-3555

PATIENT INFORMATION UPDATE

Last **First** **MI**

Primary Care Physician: **Pharmacy & Location:**

Male: Female: Date of Birth / /

Social Security Number: Language: English Other:

Race: Caucasian African American Asian Hispanic American Indian Native Hawaiian Other:

Ethnicity: Hispanic/Latino Not Hispanic/Not Latino Decline to answer race & ethnicity

Home Address Apartment No.

City State Zip Code

Mailing Address (if different than physical address)

Email Address:

Home Phone: Is it ok to leave a voice message? YES / NO	Cell Phone: Is it ok to leave a voice message? YES / NO
( )	( )
Work Phone: Is it ok to leave a voice message? YES / NO	Employer:
( )	

Emergency Contact Relationship to patient Home Phone Cell Phone

Are you a student? YES / NO Name of school attending:

How did you hear about us?

***Do you need a referral for specialty (sports medicine) treatment?**

YES NO If yes, name of referring Physician

Name of Primary Insurance: Employer:

ID Number:

Policy Holder Name: (Person who holds the insurance policy)

Date of Birth: Social Security No.

Relationship to Patient:

Insurance address:

Name of Secondary Insurance:

ID Number:

Policy Holder Name: (Person who holds the insurance policy) Relationship:

Date of Birth: Social Security No.

Relationship to Patient:

Insurance address:

Guarantor (Person responsible for payment):

Address of Guarantor if different than Patient:

Signature of Patient (or Responsible Party) **Date**

(Both sides must be completely filled out) **OVER** →

Patient's name_____DOB_____/_____/_____

PATIENT AUTHORIZATION (Treatment and Payment)

I hereby grant consent to all healthcare providers of PRINCETON SPORTS AND FAMILY MEDICINE, P.C. to evaluate and treat. I authorize PRINCETON SPORTS AND FAMILY MEDICINE, P.C. to release to my insurance company any information required, including the diagnosis and records in the course of my exam or treatment. I understand it is the patient's responsibility to let us know if pre-certification is required for any office visit, in-patient, out-patient admissions as well as any surgeries. I understand that the failure to notify our office may cause me increased out of pocket expenses such as denied claims and reduced benefits. I also understand that it is the patient's responsibility to have a referral prior to services for Sports Medicine and it must be for a PRINCETON SPORTS AND FAMILY MEDICINE, P.C. specialty provider. I hereby authorize payment directly to PRINCETON SPORTS AND FAMILY MEDICINE, P.C. for the medical and/or surgical benefits otherwise payable to me, but not to exceed charges made for such treatment.

(Initial below to acknowledge each policy)

_____I understand that I am **Financially Responsible** for the charges not covered by my insurance.

_____ I understand that outside health care and educational institutions may be participating in my treatment and care.

_____ **Cancellation Policy**: We require at least 24 hours advance notice to cancel or reschedule your appointment. IF your appointment is **NOT CANCELLED or RE-SCHEDULED** at least 24 hours in advance, you will be charged a fee of **$30.00**; this fee will NOT be covered by your insurance company.

_____ **Referral Policy:** If you are here to see one of our Sports Medicine Doctors and your Insurance requires a referral from your Primary Care Physician, and you do not have one, you will not be seen today. Please call your Primary Care Physician and request the referral before you reschedule. You must have an up to-date referral before you can be seen by one of our Sports Medicine Doctors.

_____ **Referral Policy:** If one of our PSFM Doctors is your Primary Care Physician and your Insurance requires a referral before you can be seen by another Physician, or before you have Lab Work or Imaging Studies, our staff requires at least a 72 hour notice to submit your referral.

_____ **Returned Check Policy**: If your check is returned by your Financial Institution, to PSFM, for any reason, you will be responsible for the **$40.00** check return fee.

2017 HIPPA/Release of Information

I acknowledge I have been offered a written copy of the PRINCETON SPORTS AND FAMILY MEDICINE, P.C. **"Notice of Privacy Practices" and "Patient Rights".** These brochures are located in the waiting room for the patient's convenience and can be found on our website: www.princetonmedicine.com.

*_____Initial here if you DO **NOT** authorize assignment of any person(s) to communicate with PRINCETON SPORTS AND FAMILY MEDICINE, P.C., for any reason, including your emergency contact. OR

I hereby give permission to PRINCETON SPORTS AND FAMILY MEDICINE, P.C., to disclose and discuss any information related to my medical condition(s) to/with the following family member(s), other relative(s), and/or close personal friend(s):

Name	Relationship
Name	Relationship
Name	Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that request for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

➡ Signature of Patient (or Responsible Party) _____ Date _____