**Patient Registration**
**CONFIDENTIAL**


# *Welcome to our Office*

***Ocean Heart Center***
780 Rte 37 W, Ste 220
Toms River, NJ 08755
Phone : 732-286-4801

## *1. Personal Information*

| | | | |
|---|---|---|---|
| First Name: | Middle: | Last: | |
| Street Address: | | | |
| City | State: | Zip: | |
| Phones - Home: | Work: | Cellular: | Beeper: |
| Email: | Sex: | Marital Status: | |
| Date of Birth: (mm/dd/yyyy) | S.S. # | Driver's License #: State: | |
| Employer Name: | | | Patient Occupation |
| Employer Street Address: | | | |
| City: | State: | Zip: | |

## *2. Spouse*

| | | | |
|---|---|---|---|
| First Name: | Middle: | Last: | |
| Street Address: | | | |
| City | State: | Zip: | |
| Phones - Home: | Work: | Cellular: | Beeper: |
| Employer Name: | | | Occupation: |
| Employer Street Address: | | | |
| City: | State: | Zip: | |

## *3. Emergency Contact*

| | | | |
|---|---|---|---|
| First Name: | Middle: | Last: | |
| Relationship: | | | |
| Street Address: | | | |
| City: | State: | Zip: | |
| Phones - Home: | Work: | Cellular: | Beeper: |

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|---|---|---|

## *4. Billing Information & Responsible Party*

| | | | |
|---|---|---|---|
| Billing Name: | | | Relationship to Pt: |
| Street Address: | | | |
| City | State: | Zip: | |
| Phones - Home: | Work: | Cellular: | Beeper: |
| Employer Name: | | Phone # | |
| Street Address: | | | |
| City: | State: | Zip: | |

## *5. Primary Insurance*

| | | | |
|---|---|---|---|
| Company Name: | | | |
| Street Address: | | | Effective Date |
| | | | Group # |
| City: | State: | Zip: | ID # |
| Phones: | Fax: | | Benefit Code |
| Name of Insured: | | | |
| DOB of Insured: | SS # | | Relationship to Patient |

## *6. Secondary Insurance*

| | | | |
|---|---|---|---|
| Company Name: | | | |
| Street Address: | | | Effective Date |
| | | | Group # |
| City: | State: | Zip: | ID # |
| Phones: | Fax: | | Benefit Code |
| Name of Insured: | | | |
| DOB of Insured: | SS # | | Relationship to Patient |

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## *7. Financial Responsibility*

The patient or his legal guardian is reponsible for all payments for medical services rendered by Dr. Anil K. Gupta, MD or his staff under his direct or indirect supervision or upon his approval or advice. You will receive a bill directly from this office for all services provided, and be responsible for it regardless of the insurance coverage or reimbursement. This would include services not covered by your plan or considered not necessary by your insurance carrier after they have been rendered and considered medically necessary in the best judgement of Dr. Gupta.

We make every effort to participate in as many insurance plans as possible without compromising the quality of care that we think you are entitled. However, it is possible that we might not be a participating provider for your particular plan or insurance carrier. The list of insurance carriers and their plans in which we participate or are the preferred providers for, is available with the receptionist. We encourage you to verify your coverage. Please advise us if you do not wish Dr. Gupta to render services because of your plan limitations.

A itemized bill willl be given to you to obtain reimbursement from your insurance carrier. As a courtesy, on request, we might assist you in completing the claim form required by your insurance carrier and might even submit the bill to your Primary insurance carrier on your behalf. However, It will be your responsibility to follow-up with your insurance carrier with telephone calls and respond to their inquiries regarding the claim. Regardless of their decision, payment will be due as stated on the statement. If you have any questions regarding this, please discuss with the receptionist when you come to the office. If payment is received from the insurance company you will be notified accordingly.

All payments for services, whether paid by the patient or other responsible party or your insurance carrier is due within 60 days of service. An additional grace period of 30 days may be allowed at our discretion under extraordinary circumstances. Any unpaid balance on the account which is more than 90 days old is subject to interest charges of 1.5% (or as allowed by the law) every month or fraction there of.

## *8. Authorization*

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby authorize direct payment of surgical/ medical benefits to Dr. Anil K. Gupta, MD for services rendered by him in person or under his supervision. I understand that I am financially responsible for any balance not covered by my insurance.

**AUTHORIZATION TO RELEASE INFORMATION**

I hereby authorize Dr. Anil K. Gupta, MD, to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

**MEDICARE * MEDICAID**

I request that payment of authorized Medicare/ Medicaid benefits be made to Dr. Anil K. Gupta, MD for all services furnished to me by him. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If 'Other Health Insurance' is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claims forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

*A photocopy of these assignments shall be valid as the original. I authorize the use of this signature in all my insurance submission.*

| Patient/Legal Guardian's Name (please print) | Date | Signature |
|---|---|---|
| | | |