The Rubino OB/GYN Group

101 Old Short Hills Road, # 101
West Orange, NJ 07052

33 Overlook Road #108
Summit NJ 07091

731 Broadway
Bayonne, NJ 07002

67 Walnut Avenue, # 101
Clark, NJ 07066

Patient Information Sheet

(please print)

Date:_____

Name:_____ _____
Last Mi First Refer to as

Address: _____
Apt City St Zip

DOB: ___/_____/_____ AGE: _____ SS#: _____

Home Phone#: _____Cell Phone #: _____ Work #: _____

Preferred Contact #: (please circle one) Home / Cell / Work

E-Mail Address:_____

Please Circle: Single / Married / Divorced / Separated / Widowed

Please provide the following information so that we will be in compliance with new Federal Government Health laws. Thank you for your cooperation.

Race:
____ American Indian or Alaskan Native
____ Asian
____ Asian Indian
____ Black or African American
____ Hispanic
____ Native Hawaiian or other Pacific Islander
____ Refuse to report/unreported
____ White

Ethnicity:
____ Hispanic or Latino
____ Non-Hispanic or Latino
____ Refuse to report/unreported

Preferred Language: _____

Religion:_____

The Rubino OB/GYN Group

Preferred Pharmacy:

Name: _____

Address: _____

Phone Number: _____

I authorize The Rubino OB/GYN Group to review my medication history as available through the E-Prescribe Network.

Please also provide this insurance information:

Insurance Company_____ ID#_____

Subscriber Name:_____

Relationship to Subscriber _____Self _____Spouse _____Dependent

If other than patient – Date of Birth & SS# :_____

IMPORTANT - Please read:

Persons authorized to receive my health and medical information. Please be sure to include family members and friends.

_____

_____

_____

_____

_____

Signature: _____ **Date: _____** v7-7-16

The Rubino OB/GYN Group Assignment of Benefits/Financial Disclosure

Assignment of Benefits: I Authorize Payment of Medical Benefits To: The Rubino OB/GYN Group, PA
101 Old Short Hills Road, #101, West Orange, NJ 07052

I Authorize The Rubino OB/GYN Group (ROG) to submit claims to my primary insurance carrier on my behalf. I also authorize assignment of benefits directly to the office, and release of my medical records requested by my insurance carrier(s). I also acknowledge that if ROG does NOT receive payment from my Insurance carrier, I will be held responsible for the balance of my bill. I agree that I will be responsible for any coinsurance and/or deductible amounts assigned to me by my insurance carrier. I have read all the information on this form and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information. I understand that ROG DOES NOT SUBMIT claims to secondary carriers.

I agree that I must pay any applicable copay at the time of my visit and that failure to pay will result in rescheduling of my appointment. I understand that my insurance company determines the proper copay amount for my visits and that I will be billed for an additional copay amount if my insurance company assigns that responsibility to me, or will be billed for copay on an office procedure if my insurance company deems so after processing my claim. I agree that if I do not present valid insurance information at the time of my visit I will pay the full charge for an office visit prior to receiving service. If valid insurance information is provided at a later date, ROG will reimburse me the appropriate amount following payment by my insurance carrier. I agree that if I fail to provide the proper insurance information at the time of the visit I will pay an administrative charge to refile insurance claims. I agree that any patient balances billed to me are due within 30 days of the statement date and that simple interest of 1% per month will be applied to outstanding balances that are not paid by the due date. I agree that I will pay a $50 charge for failing to cancel a scheduled appointment with 24 hour notice and a $100 charge for procedures. I agree that I will pay a collections fee of 35% if my account is forwarded to a collections agency. I agree that I will pay a combined collections/attorney fee of 50% if my account is forwarded to an attorney for legal proceedings and a favorable judgment is rendered to ROG. I agree that I will promptly inform ROG if my address changes and am subject to an administrative fee of $2 to cover USPS forwarding charges and/or returned mail charges imposed upon ROG by the USPS.

I understand that any laboratory tests not performed directly in a ROG office will be directed to an outside laboratory for processing, based on insurance coverage, or at direction of this office if patient has no insurance coverage; and further understand that I am responsible for any laboratory balances not covered by insurance. ROG will endeavor to assist patient with laboratory billing issues but in no way assumes any responsibility for laboratory bills unless the bill is a result of an error caused directly by ROG.

Effective October 1, 2012, ROG will begin processing checks received for payment electronically. This means we will send an image of each check to the bank for processing rather than the original check. When you provide a check as payment, you authorize the ROG either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction.

Failure to agree to all of the terms in this document, unless specifically authorized by ROG, and signed, will result in termination of the patient/physician relationship with all providers in the Practice.

Signature _____Date:_____

Print Name_____