2963 Marne Highway, Mount Laurel, NJ 08054
• 856.638.1990 • Fax 856.583.0359
• www.bruneaufamilycare.com

Patient Information Sheet

Last Name: _____ First Name: _____ MI:_____

Address: _____ Apt. #_____

City: _____ State: _____ Zip Code:_____

Home Phone:_____ Work: _____ Emergency:_____

Cell Phone # _____E-mail Address: _____

EmployerName:_____Occupation_____

Marital Status: Married Single Divorced Separated Widowed Other

SS#: _____ Patient Date of Birth; _____ Sex: M F_____

Ethnicity:
Hispanic or Latino__
Not Hispanic or Latino__
Unknown__

Race:
American Indian or Alaska Native__
Asian__
Black or African American__
Native Hawaiian or Other Pacific Islander__
White__
Other Race__

Referred by:_____

Primary Insurance Information

Insurance Plan Name: _____ Effective Beginning Date: _____

Subscriber Name: _____ Relationship to insured: _____

DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# _____ Sex: M F Employer: _____

Group Name: _____ Group #: _____ Policy #: _____

CoPay Amt: _____

Secondary Insurance Information

Insurance Plan Name: _____ Effective Beginning Date: _____

Subscriber Name: _____ Relationship to insured: _____

DOB: _____ Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

SS# _____ Sex: M F _____

Group Name: _____ Group #: _____ Policy #: _____

CoPay Amt: _____

Name: _____ SS#: _____ DOB: _____

Please read and sign authorization below:

1. I hereby authorize direct payment of medical benefits to Bruneau Family Care, P.C. for services rendered. I understand that I am financially responsible for any balance not covered by my insurance company. I certify that the information I have given in applying for payment is correct and I authorize release of all records upon request. A photocopy of these assignments shall be valid as the original.

2. I hereby authorize Bruneau Family Care, P.C. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

3. I agree and understand that it is my responsibility to obtain necessary medical records that are requested by the Bruneau Family Care, P.C. office.

4. Co-payments/Deductibles are due at the time of service and insurance cards need to be presented at every office visit.

5. Any checks that are returned by your bank for any reason will result in additional fee of $35.00 which will be added to your balance.

6. I understand that my insurance carrier determines settlement of this claim based on the terms of my policy in place at the time of service. Should there be any balance due after insurance settlement, I understand that it is my responsibility (co-pay, deductible, co-insurance). I understand that as these services were performed for me or my legal dependent, I am financially responsible for all charges whether or not paid by the insurance. If this balance is not paid within 120 days, I understand that my account will be turned over to collections. At that time, I will be responsible for both the outstanding balance AND all collections costs associated with the account.

7. Please note that if for any reason, you are not able to make your appointment, we require notification at least 24 hours in advance. If you are not able to make your appointment for any reason and do not notify us, you will be charged a $25.00 fee regardless of your required co-payment.

8. Due to billing rules established by insurance companies, Medical problems discussed during your yearly physical may result in collection of you copay or deductible.

9. All forms that need to be completed will be subject to a fee of $20.00. Forms may take up to 4 business days for completion Comprehensive forms/letters may require additional fees. Payment is due at request of service. A $10 fee will be accessed for all forms brought to the office visit.

10. **All routine laboratory and radiology test results may take up to two weeks to get results, unless ordered stat by our physicians. If it has been 3-4 weeks since you went for the test and have not hear from the office, it is the patients responsibility to call the office and request results.**

11. Insurances requiring a referral must notify the office four days prior to your appointment, unless ordered stat.

12. Please be advised in the event you are 20 minutes late for your appointment you may be asked to reschedule your appointment.

13. **Please allow 72 hours for prescriptions to be refilled.**

14. Bruneau Family Care, PC is in the process of becoming a certified Medical Home. Medical Homes are the foundation for a health care system that gives more value by achieving the "Triple Aim" of better quality, experience and the cost.

15. Patient Portal. We encourage you to set up a portal account. This can facilitate better communication with us. Our office provides a two way communication between the patient and the office staff via our system. This should be set up at your initial visit but we can set up any time. A working email is required. The office will send the patient an email from our office. A link will be provided for the patient to set up a username and password. This is not to be used for urgent/ emergency care.

16. Office hours are as follows:
    Monday 8:00am-6:00pm, Tuesday 8:00am-4:30pm, Wednesday 8:00am-6:00pm, Thursday 8:00am-4:30pm, Fridays 8:00am-3:30pm, Saturdays 8:00am-11:00am only during the academic school year. The office is closed on Saturdays from June to September. We reopen on Saturdays after Labor Day Weekend.

17. **Procedure for when office is closed:**
    If you are experiencing a life threatening emergency, you are to dial 911.
    If you have a medical emergency that cannot wait for routine business hours, you dial the main phone number and listen to the message. The message will give you a phone number to call the physician on call.

18. **As a patient of Bruneau Family Care, I will be responsible for following the physician's orders to maintain a healthy life. I will also be responsible to co-manage with my medical team any self-plans such as care of my chronic diseases such as diabetes, hypertension and heart disease. In addition I agree to co-manage with my medical team diet and exercise. If I fail to be non-compliant of the physician's orders, I may be asked to leave the practice.**

My signature below indicates that I have fully read and understand the policies in place for services provided to me by the physicians of Bruneau Family Care, P.C.

Name(print):_____

Signature:_____ Date:_____

If relative, state relationship:_____