2963 Marne Hwy, Mt. Laurel, NJ 08054
Phone: 856-638-1990 - Fax: 856-583-0359
bruneaufamilycare.com

Patient Information Sheet

Last Name: ____________________ First Name: ____________________ MI: ______

Address: ____ Apt. #: ___________

City: _____________________ State: _______ Zip Code: _______________

Home Phone Number: ____________________ (preferred___)

Cell Phone Number: ___________________ (preferred___)

E-mail address: _________________________

Employer Name: __________________________ Occupation: __________________________

Marital Status: Married Single Divorced Separated Widowed Other

SS#: ___________________ Date of Birth: __________________

Sex: Male Female Unknown Prefer Not to Answer

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 (please identify): __________________

Who you referred you to Bruneau Family Care? ____

Primary Insurance Information

Insurance Plan Name: ________________________ Effective Beginning Date:_____________

Subscriber Name: ___________________________ Relationship to Insured:_______________

Group Name:________________________Group #: ___________Policy #:_________________

CoPay Amount: ______

Subscriber Information

DOB:_____________________________

Address:_________________________City:___________________State:_____Zip:__________

SS#___________________Sex: M__F__ U__ Employer:______________________________

Secondary Insurance Information

Insurance Plan Name: ________________________ Effective Beginning Date:_____________

Subscriber Name: ___________________________ Relationship to Insured:_______________

Group Name:________________________Group #: ___________Policy #:_________________

CoPay Amount: ______

Subscriber Information

DOB:_____________________________

Address:_________________________City:___________________State:_____Zip:__________

SS#___________________Sex: M__F__ U__ Employer:______________________________

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 Bruneau Family Care, P.C.

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 $30.00 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 $25.00. 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 $15 fee will be accessed for all forms brought to office visit.

10. It takes approximately 2 weeks from the day you go for laboratory or radiology testing for you to receive a phone call from the office regarding your results. If it has been 3 weeks since you went for the test and have you not heard from the office, it is your 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 that in the event you are 20 minutes late for your appointment, you may be asked to reschedule.

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

14. We encourage patients to set up a Patient 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 it up at any time. A working email is required. The office will send the patient an email from our office and 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.

15. Office hours are as follows:
    M: 8:00am - 6:00pm
    T: 8:00am - 4:30pm
    W: 8:00am - 6:00pm
    Th: 8:00am - 4:00pm
    F: 8:00am - 3:30pm
    S: 8:00am - 11:00am (only during the academic school year, the office is closed on Saturdays from June to September and reopens on Saturdays after Labor Day Weekend)
    *all times are subject to change

16. Procedure when the office is closed: If you are experiencing a life threatening emergency, dial 911. If you have a medical emergency that cannot wait for routine business hours, call the main office line to be directed to an on-call RN service.

17. As a patient of Bruneau Family Care, I will be responsible for following the physician's orders to maintain a healthy lifestyle. I will be responsible for co-managing with my medical team any plans such as the care of chronic disease like diabetes, hypertension, and heart disease. In addition, I agree to co-manage with my medical team my diet and exercise plan. If I fail to be compliant with 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 Bruneau Family Care, P.C.

Name (print):________________________________

Signature: ___________________________________ Date: _____________________

If Relative, State Relationship: ______________________