LAKEVIEW MEDICAL ASSOCIATES, P.C.
125 ROUTE 46
BUDD LAKE, NEW JERSEY 07828

PATIENT REGISTRATION

DATE:_____ PATIENT'S NAME:_____

PATIENT'S ADDRESS:_____
(STREET) (CITY) (STATE) (ZIP)

HOME PHONE:_____ WORK PHONE:_____ CELL PHONE:_____

BIRTH DATE:_____ SOCIAL SECURITY#_____MARTIAL STATUS_____

PATIENT'S OCCUPAATION:_____EMPLOYER:_____

RESPONSIBLE PARTY (IF UNDER 18 YRS):_____

EMAIL ADDRESS:_____

REFERRED BY:_____

INSURANCE INFORMATION

PRIMARY INSURANCE_____ SUBSCRIBER'S SS#_____

SUBSCRIBER'S NAME_____ SUBSRIBER'S DOB_____

INSURANCE ID NO._____ GROUP NO._____ COPAY:_____

SECONDARY INSURANCE_____ SUBSCRIBER'S SS#_____

SUBSCRIBER'S NAME_____SUBSRIBER'S DOB_____

INSURANCE ID NO._____ GROUP NO._____

I understand and agree that payment is expected at the time of service. I authorize the release of any medical records necessary to process insurance claims and payment of benefits be made to Lakeview Medical Associates, P.C. for all services rendered.
In consideration for any credit extended to me I agree to be responsible for all charges against my account and agree to pay in accordance with the following:

1. I hereby accept full responsibility for all charges incurred. I agree to pay all charges at the time of service unless Lakeview Medical agrees to file an insurance claim on the patient's behalf. In the event that an insurance claim is denied, not paid by an insurer, or if the balance due from the patient is over 30 days outstanding, I hereby authorize Lakeview Medical to charge my credit or debit card on file to pay any remaining balance.
2. A collection fee of $50.00 will be added if referred to a collection agency.
3. Any returned checks are subject to a service charge of $40.00 in addition to the outstanding balance.
4. We require 24 hours notice for cancellation. We reserve the right to charge $40.00 for appointments cancelled or broken without 24 hours notice.
5. HIPPA WAIVER. I hereby consent to the terms and conditions stated in the HIPPA WAIVER Dated April 11, 2008

I give permission to share my medical information with:_____

SIGNATURE OF RESPONSIBLE PARTY:_____DATE:_____