INTERNET MEDICAL GROUP, P.C.

Please provide photo ID, Insurance & Prescription Card. We will need to make copies. Thank You!

REGISTRATION FORM

Patient Information

Patient Information

Last Name: | First Name: | Middle:

Date of Birth: | Sex: ☐ Male ☐ Female ☐ Other:_____ | Marital Status: ☐ SIN ☐ MAR ☐ DIV ☐ WID ☐ SEP | Social Security #:

Address: | Apt/Floor: | City: | State: | Zip:

Email Address: | Preferred Method of Contact for Reminder Calls or Electronic Messages (may choose more than one): ☐ Voice ☐ Text ☐ Email | Preferred Phone Number to Contact: ☐ Cell ☐ Home ☐ Work

Cell Phone: | Home Phone: | Work Phone:

Employer Name: | Employment Status: ☐ Employed Disabled ☐ Retired ☐ FT/PT Student ☐ Self-employed ☐ Unemployed | Occupation: | Referred by:

Race:
- ☐ Caucasian/White (C)
- ☐ Black/African American (B)
- ☐ Asian (A)
- ☐ Native Hawaiian/Pacific Islander (P)
- ☐ American Indian/Alaska Native (I)
- ☐ Refuse (N1)
- ☐ Don't Know (N2)
- ☐ Other (N3)

Ethnicity:
- ☐ Latino/Hispanic
- ☐ Other
- ☐ Not Reported / Refused

Primary Language:
- ☐ English
- ☐ Spanish
- ☐ Italian
- ☐ French
- ☐ Chinese
- ☐ Japanese
- ☐ Other: _____

Emergency

Emergency Contact

Full Name: | Date of Birth: | Relationship:

Cell Phone: | Home Phone: | Work Phone:

Consent

Medical Consent - Permission to release information to the person below (i.e., appts/results).

Full Name: | Date of Birth: | Relationship:

Cell Phone: | Home Phone: | Work Phone:

Insurance

Medical Insurance

Primary Medical Insurance		***Secondary Medical Insurance***	
Ins. Co. Name		Ins. Co. Name	
Policy Holder Name		Policy Holder Name	
Policy Holder's DOB		Policy Holder's DOB	
Policy Holder's SS#:		Policy Holder's SS#:	
Relationship to Policyholder		Relationship to Policyholder	

Pharmacy

Prescription Benefit Plan/Insurance

Name of prescription insurance plan:

Pharmacy Name: | Pharmacy Phone #:

I certify that I have read and agree to Internet Medical Group's (IMG) payment policy. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. Keep in mind that your insurance policy represents a contract between you and your insurance company. As a courtesy we will file your insurance claim, if you assign the benefit directly to the physician. If your insurance company does not pay IMG within 45 days, we may have to look to you for payment. We have made prior arrangements with many insurance carriers to accept assignment of benefit. We will bill them directly and you are required to pay any copays that are required by your insurance at the time of your visit. Payment is due at the time of service unless arrangements have been made in advance by you or your insurance carrier. Failure to make payment at the time of your visit will result in a $10 admin fee for each missed payment. Payments are accepted in cash, checks or credit cards. A $25 returned check fee will be charged for checks returned due to insufficient funds. Payment will be due upon receipt of a statement from the office. I hereby assign to IMG all money to which I am entitled for medical expenses related to the services performed from time to time by IMG, including hospitalizations, but not to exceed my indebtedness to IMG. I authorize IMG to release any information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. Failure to keep your appointment or cancellations made less than 24 hours with office, may result in a $50 fee. I choose to receive communications from IMG by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment.
MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to IMG. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

☐ I have reviewed a copy of Internet Medical Group's Privacy Notice. _____ **(INITIALS)**

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____ Date: _____

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PAYMENT POLICY

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies. By signing the patient registration form, you are acknowledging that you have read, understand, and agree to Internet Medical Group's (IMG) financial payment policy.

Patient Responsibility:

- Keep in mind that your insurance policy represents a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim if you assign the benefit directly to the physician. If your insurance company does not pay IMG within 45 days, we may have to look to you for payment.

- Not all insurance plans cover all services. In the event your insurance plan determines a service is "not covered" or if you are not covered by an insurance plan you will be responsible for the full charge. Payment will be due upon receipt of a statement from the office.

- IMG will only bill your primary and secondary carrier. If you would like a third insurance to be billed, you will be responsible for doing so.

- If you are insured by an insurance plan that our physicians do not participate with or if you do not have insurance, you must pay for services prior to your visit or make payment arrangements with the office. The billing office will then provide you with a HICFA 1500 form, so you may request reimbursement from your non-participating insurance carrier.

- ***Co-pays:*** Payment is due at the time of service. We accept payments in the form of cash, checks or credit cards. A $25 returned check fee will be charged for checks returned due to insufficient funds. Failure to make payment at the time of your visit will result in a $10.00 administrative fee for each missed payment.

- ***Hospitalization:*** We will bill your insurance carrier for all physician services provided in the hospital. You are responsible for any balance that is not covered by your insurance plan.

- ***Balance****:* Statements will be sent to you for any balance you may have. If no payment is received with your statement, follow-up collection letters will be sent seeking payment. Unpaid balances over 90 days will be referred to an outside collection agency. In addition, failure to pay for services in a timely manner may result in discharge from IMG.

- ***Appointment/Schedule Fee****:* If you schedule an appointment with our office and you are unable to keep your appointment, we kindly ask for you to notify us 24 hours in advance to avoid a $50 FEE.

- ***Auto Accident Claims***: We will bill your auto policy in the event of an auto accident. If someone else is responsible for the accident, we will NOT bill his or her insurance. You will be responsible for our bill, and you will need to seek reimbursement from the other party.

- ***Workers Compensation Plans***: You are responsible for ensuring that your employer submits the "First Report of Injury". If your insurance company denies the claim because your employer failed to file the notice, the bill will become your responsibility.

I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance; copay, or any service(s) deemed a "non-covered benefit" by my insurance company. In addition, failure to pay delinquent account balances may result in termination of care from Internet Medical Group. We thank you in advance for your co-operation.

INTERNET MEDICAL GROUP, P.C.
181 Franklin Avenue Suite 204
Nutley, NJ 07110
Tel. 973-667-8117
Fax. 973-667-6642

Dr. Edward Vecchione ☐
Dr. Joseph Brignola ☐
Dana Brignola, PA ☐
Judyth Valera, PA ☐
Samantha DeAlmeida, APN ☐

Medical Record Release

Patient Name:	Date of Birth:

I hereby authorize and request Internet Medical Group:

☐ *To release medical records to:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

☐ *Obtain medical records from:*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Fax: _____

Please **FAX** all records to **973-667-6642.**

Check all that applies:

☐ Chart Notes
☐ Lab Results
☐ X-rays/Diagnostic Tests
☐ Immunizations
☐ Medical Reports
☐ All Records
☐ Other: _____

I understand that I may revoke this authorization in writing at any time to IMG, except to the extent that information has already been released in response to this authorization. Unless otherwise revoked, this authorization will not expire. My signature below authorizes release of information unless I have marked NO and initialed it.

☐ Yes ☐ No Initials _____

Signature/Legal Responsible Party: _____

Relationship to Patient if not Patient: _____

Date: _____

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PATIENT HISTORY/INFORMATION

Name:	DOB:	Date:

Medications: *Please list all medication(s) you are currently taking, including over the counter/vitamins.*

	Name of Medication	*Dose*	*Frequency*
1.			
2.			
3.			
4.			
5.			

Allergies: *Please list any types of allergies you have and your reaction.* [e.g., food, medication.

	Allergy	*Reaction*
1.		
2.		
3.		

Surgical History: *(Please list all surgeries that you have had, and approximate dates performed).*

	Surgery/Procedure	*Surgeon/Hospital*	*Month/Year*
1.			
2.			
3.			
4.			

Social History:

Smoking/Tobacco Use: ☐ Current ☐ Past ☐ Never Type: _____ Amount/Day: _____ #of Years: _____

Alcohol: ☐ Current ☐ Past ☐ Occasional/Social ☐ Never Drinks/week: _____

Recreational Drug Use: ☐ Current ☐ Past ☐ Occasional/Social ☐ Never Type: _____

Sexually Active: ☐ Yes ☐ No

How often do you engage in exercise/physical activity? ☐ Everyday ☐ Weekly____/days ☐ Monthly ____/days ☐ Never

How often do you get the social and emotional support you need? ☐ Always ☐ Usually ☐ Sometimes ☐ Rarely ☐ Never

Family History: (Please list all relatives that has/had a major illness.)

Father History:	**Mother History:**	**Sibling(s):**
☐ Alive/Age: ____	☐ Alive/Age: ____	Brothers? ☐ No ☐ Yes *How many? ____
☐ Deceased/Age:____	☐ Deceased/Age:____	Sisters? ☐ No ☐ Yes* How many? ____
Cause of Death? _____	Cause of Death? _____	

Please list any family history of major illness and relationship:

Relationship	*Type of Illness*

Please list other medical providers/specialists you see on a regular basis (e.g.cardiologist, mental health, kidney doctor…)

Name of Doctor	*Reason you see this doctor.*

Colonoscopy	Yes/ No	
Mammo	Yes/ No	
Bone Density	Yes/ No	
Eye Exam	Yes/ No	
Female Only (Below This Line)		
Last Menstrual		
PAP		

Patient Signature: _____