MIDDLESEX
WEIGHT MANAGEMENT

PATIENT INFORMATION FORM

Patient Name: (Last)_____(First)_____(MI)_____

Name you prefer to be called: _____

Patient Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cellular: _____

Birthdate: _____Age: _____Sex: M F

Email: _____

Employment Information

Patient Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Work Phone: _____Ext. _____

In Case of Emergency

Name: _____ Relationship: _____ Phone: _____

Patient's Spouse: _____ Phone: _____

Family Physician: _____ Phone: _____

Referred by: _____

Financial Policy

Thank you for selecting Middlesex Weight Management for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy.

We will work with you and your insurance carrier to optimize your insurance benefits and reduce your out-of-pocket cost. We plan to bill your insurance for RPM (Remote Patient Monitoring), medical nutritionists, and office appointments. Usually, providers are not allowed to balance bill patients even if there is partial insurance coverage because weight management is not fully recognized. Many insurance carriers may not cover these services and there will be an out-of-pocket cost to you. By signing this agreement, you will be allowing us to balance bill for services not covered by your insurance company.

Please be advised that payment for all services will be due at the time of services rendered unless prior arrangements have been made. In order to participate in Middlesex Weight Management, we request that you sign our credit card on file policy so we can charge your card for any patient financial balance after the claims are adjudicated. You will be asked to provide a credit card when you check-in for your first visit and we will scan the card into our system. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. We will send you a receipt for your records.

If allowed by your employer, these charges may be applied to your medical flex fund.

I am aware that not all services provided by Middlesex Weight Management will be covered by my insurance company.

I authorize Middlesex Weight Management to charge my credit card for the estimated patient responsibility at time of service. The patient responsibility after insurance claim processing identifies the amount that is my responsibility and all services not covered by my insurance carrier upon receipt of explanation of benefits by Middlesex Weight Management. This authorization will remain in effect until I cancel this authorization in writing and my account is in good-standing.

__AMEX __Visa __Mastercard __Discover __Debit Card

Credit Card Number _____

Expiration date ___/___/_____ Security Code _____

Cardholder Name

_____

Signature _____ Date _____

Address _____

City_____ State_____ Zip_____

This authorization applies to the following patient(s):

Patient Name / DOB / Relationship

_____

_____

I have read and understand all the above and have agreed to these statements.

_____

Patient's Signature Date

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