Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

PLEASE PRINT VERY CLEARLY

Line items printed in **bold** on this page are required fields, if they apply. Thank you for your assistance.

■ Patient Information

Name (Last, First, Middle) _____ **Today's Date** _____

Birthdate _____ **Soc. Sec. #** _____ **Home Phone** _____

Email address _____ **Cell Phone** _____

Address _____ Work Phone _____

City _____ **State** _____ **Zip** _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Partnered **Sex:** _____

Race: ☐ Black / African American ☐ White / Caucasian ☐ Hawaiian / Pacific Islander ☐ American Indian ☐ Asian ☐ Unknown ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Prefer not to specify

How did you hear about us? _____

■ Primary Medical Insurance

Insurance Company _____

Insurance ID # _____ Group # _____

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Policyholder's DOB _____

■ Secondary Medical Insurance

Insurance Company _____

Insurance ID # _____ Group # _____

Policyholder's Name (Last, First, Middle) _____

Relationship to Patient _____ Policyholder's DOB _____

■ Pharmacy Benefit Insurance

Insurance Company _____

ID # _____ Group # _____ BIN # _____ PCN # _____

■ Assignment and Release

I hereby authorize payment directly to Beacon Infusion Healthcare Services LLC and/or its affiliates, partners and licensees (including, without limitation, J Medical Practice LLC, Jonathan Wiesen MD PLLC, and/or Sherman Infusion Services Inc.) of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered for me or for my dependents. I authorize the providers, staff and billing agents of this practice to release any information required to secure the payment of benefits, and I allow them to submit appeals and requests on my behalf. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above. Should any insurer, vendor or provider require acknowledgement of receipt for any services, therapies and/or products, the signature on this page suffices and can be applied by you to those acknowledgements.

Signature: _____ **Date:** _____

Patient Name: _____ **Date of Birth:** _____

■ Emergency Contact

In the event a medical emergency arises, or you need to be transported from our practice to an emergency room or other medical treatment facility, please provide us with an emergency contact person.

Name: _____ Relationship: _____

Cell Phone: _____ Home Phone: _____

■ Present Medical Condition

What is the underlying medical condition and the medication for which you are seeking injection or infusion treatment with us?

_____

Which medical provider ordered the infusion or injection treatment? Please provide their name, address and phone number.

_____

Please list your other current physicians:

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

Name: _____ Phone: _____ Specialty: _____

■ History

Which surgical procedures have you had and when did you have them?

_____

What current health conditions do you have other than the reason for your visit today?

_____

Please list any chronic / ongoing medical conditions that you have:

_____

What medications (and dosage, if possible) are you currently taking?

_____

If you have any allergies (whether medical, environmental, or food-related), please list them here:

_____

Do you currently smoke? Yes No If Yes, what do you smoke: _____

If Yes, how many per day? _____ If No, did you smoke in the past? Yes No

Do you currently drink alcohol? Yes No If Yes, how many drinks per day? _____

When did you last consume alcohol? Within the past 6 hours Within the past 2 days 3 or more days ago

If you do not drink now, did you drink in the past? Yes No How many drinks per day in the past? _____

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BILLING and COLLECTION POLICIES

Upon scheduling and registration we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's full address, date of birth, and phone number as well. For collection purposes, we require social security numbers as well. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior.

Medicare: If you have coverage with Medicare or Medicare Advantage, it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a coinsurance. Any portion of this deductible and coinsurance that is not covered by a supplemental carrier will be your financial responsibility to pay. Medicare Advantage beneficiaries may be responsible for a copayment, coinsurance, deductible, or any combination thereof. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare and another insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. You are responsible for your financial obligations under you Medicare Advantage or Original Medicare with supplemental insurance plan, and as such as responsible for knowing which coverage you have. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding this provision. Please note that when single dose vials are utilized, there is a charge for both the administered medication as well as any wastage as per standard industry practices.

Participating Commercial Insurance: If you have an insurance plan which we participate with, you agree to comply with all the plan's provisions and obligations. You are responsible to pay your copayment, if applicable, at the time of service, as payment of any other financial obligations for the visit, including without limitation coinsurance and/or deductible. If your plan advises us at any time that you do not have coverage for any services rendered, or you are not covered for services rendered for any reason, you will be billed for the entire balance. If your plan makes payment directly to the patient or policy holder for services rendered, you are responsible to turn the entire payment over to us immediately upon receipt, along with a complete copy of the Explanation of Benefits. Should you be issued payment by the insurance carrier and not promptly turn it over to us in whole, legal action will be pursued and you may be discharged as a patient from this practice. Bills for any balance(s) applied to the patient's financial obligation are due immediately upon receipt. Please note that when single dose vials are utilized, there is a charge for both the administered medication as well as any wastage as per standard industry practices.

Self-Pay: Patients without insurance, whose insurance coverage does not cover the services rendered for any reason, or who have insurance with which we do not particulate, shall pay for all services rendered at the time of service. Payment must be made in full prior to rendering services. If additional services are provided beyond what was paid for upon checking in, the balance is due upon checking out. You may request a detailed receipt after services are rendered, and we will issue you one which you can use to file for reimbursement from your insurance carrier. We make no warranties about what, if anything, your insurance carrier may reimburse you for our services.

Financial Obligations: It is our right to bill you for any portion of your treatment that your insurance assigns to your responsibility, and any balance that your carrier does not pay. It is your responsibility, as detailed by the terms of your health insurance policy, to pay any such portion. If you do not remit full payment on any such bills within a reasonable period and with reasonable notice, your account may be sent to collections. If that happens, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. If you bounce a check, you will be responsible for a $40 fee, and thereafter payment will only be accepted via cash or credit card. Failure to show for an infusion, or cancellation on less than 24 hours' notice, constitutes a no-show and is subject to a $350 fee. If you change mailing address or email address you are responsible to arrange for forwarding and to notify us of the change in a timely fashion – a change of address does not result in a change your payment is due. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Health insurance non-payment: Services that have not been paid by your participating health insurance carrier within 60 days of claim submission, whether or not your plan is one with which we participate, wholly become your responsibility to pay in full. If your carrier later pays us for those services, you will be reimbursed for the difference.

Financial Security and Collections: It is our policy to request patients to keep a credit card on file as financial security against deductibles, co-insurance and other instances of patient balances due to us as outlined in this document. You shall continue to be sent invoices in the mail. However, if you do not pay your invoices in a timely fashion, we reserve the right to add a 10% penalty for failure to pay your invoices and charge the credit card on file for the new total amount as a stop-gap to avoid sending accounts to collections. However, if you do not pay your invoices in a timely manner, and you do not provide a credit card for our files, or the card you provide is not valid or funded when we attempt to use it, your account shall be sent to collections. In that event, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Please provide your credit card security information here, and give the receptionist the card to scan and/or copy:

Circle: Visa MC AMEX Card #: _____ Expiration: _____ Security #: _____

Is this an HRA or Flex Spending card? Y / N

Credit card billing address + ZIP: _____

Credit Card Charges: If you pay for your charges with a credit card and feel the charges are either unwarranted or otherwise nor your responsibility based on the provisions of your health insurance plan, you must first contact our billing department before contacting your credit card vendor. If you contest credit card charges without first contacting us, or you contest credit card charges which your insurance carrier has applied to your financial responsibility, and those charges are reversed by the credit card vendor or merchant bank, your balance due may be immediately treated as overdue debt, a collections fee may be appended, and the entire account may be sent to our collection agency, as outlined above, in the Financial Security and Collections paragraph.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees for any goods and services furnished to me or my dependents.

Patient Name (Please print clearly): _____

Signature of Patient: _____ Date: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

♦ Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees, their staffs and providers may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations (TPO). I understand and acknowledge that Beacon Infusion Healthcare Services LLC's Notice of Privacy Practices has a more complete description of such uses and disclosures.

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand and acknowledge that Beacon Infusion Healthcare Services LLC reserves the right to revise its Notice of Privacy Practices at any time, and that a revised version of that notice may be obtained sending a written request to the Privacy Officer at the practice.

♦ I permit Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees to leave telephone messages regarding my appointments, prescription renewals, lab results, and all other PHI, may be left for me on voicemail systems and answering machines, or given the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

♦ I agree that my PHI may be shared with my spouse (if applicable).

♦ I agree that my PHI may be shared with my other medical providers.

♦ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

♦ I agree that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may use my information including PHI for operational, fiscal, promotional and development purposes.

♦ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Beacon Infusion Healthcare Services LLC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

♦ I agree that my PHI may be shared with my credit card vendor(s) to permit Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees to submit records to support its charges if needed.

♦ I agree that Beacon Infusion Healthcare Services LLC and its affiliates, partners and licensees may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly): _____

Signature of Patient: _____ Date: _____