



Dr. Matthew G Pinto
Andrea Farwell, NP

Section 1

First Name: _____ Middle Initial: _____ Last Name: _____

Previous Name: _____ DOB: ____ / ____ / ____ SS#: _____ - ____ - ____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: (_____) _____ - _____ Cell: : (_____) _____ - _____

Work Phone: (_____) _____ - _____ Extension: _____

Ethnicity: _____ Race: _____ Language: _____

Marital Status: Married Single Widowed Divorced Email Address: _____

Section 2

Insurance Company: _____ Subscriber #: _____

Responsible Party Name: _____ Relationship: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone #: _____

**We will need to scan or copy your insurance card. Please be sure to have your
CURRENT/UPDATED card with you.**

**You will be personally responsible for payment of your claim if your insurance information is
incorrect. Thank you for your cooperation.**

Consent for Outpatient Services

I consent to examination, routine testing and medical treatment, which my doctor believes is necessary. I understand medicine is not an exact science; no guarantees or promises have been made to me about my treatment. I accept that the services provided are given in the least restrictive setting and manner to meet my needs. If special procedures are needed, I will be asked by my doctor to give separate informed consent. I have the right to refuse any drugs, treatment or procedures. I understand that my doctor is not responsible for my personal belongings during my care. I have read and understand this consent for care and my questions have been answered. My signature means I agree to the above. I can ask for a copy of this form.

Patient/Authorized Party

Date _____

Print Name

Witness Name and Initials

Date _____

Assignment of Health Insurance Benefits and Agreement for Financial Responsibility

I authorize payment to my doctor of any health insurance benefits that are payable to me, including Medicare payments, Medigap payments, and/or payments under any Employer Self-Funded Medical Expense Reimbursement Plan as governed by the Employment Retirement Income Security Act (ERISA), and/or payments from private insurance companies. I certify that the information that gave my doctor to bill for payment is correct. I assign and transfer to my doctor the right to act in my place to bill and collect all payments that are payable to me under any private or government plan of health benefits and/or to sue any insurer or other responsible party to obtain these payments. These payments may not be more than the balance due my doctors and/or hospital and I understand that I have to pay my doctor for all charges not paid by my health insurance. This payment authorization, assignment of benefits and agreement for financial responsibility is also binding on my administrators, executors, heirs and successors. I have read this assignment of benefits; I understand this assignment of benefits, and my questions have been answered.

Patient / Authorized Party

Date _____

Witness Name and Initials

Date _____

Authorization to Release Information for Treatment, Payment or Operations

I understand my doctor is allowed to use and disclose my health information for treatment, payment, or operations and I understand this use is allowed by law. I understand that when my doctor uses and discloses my health information as described in this authorization, my doctor may disclose general information contained within my medical record. I understand that full disclosure of my HIV, drug and alcohol abuse, or mental health treatment record will not occur without my specific consent relating to these conditions. My signature below means that I have read this authorization and I understand this authorization to release my health information.

Patient / Authorized Party

Date _____

Witness Name and Initials

Date _____

Verbal Consent

If consent from the patient is verbal because of the patient's physical inability to sign this consent form, then please check this box and have a staff member sign as a witness above and a second witness sign here.

Second Witness' Name

Date _____

Glendale Primary Care

Dr. Matthew G. Pinto
Andrea Farwell, NP
363A West Browning Rd
Bellmawr, NJ 08031

In order to establish optimal relationship with our patients and avoid misunderstandings and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of the office. **PAYMENT IS REQUIRED FOR ALL SERVICES AT THE TIME THEY ARE RENDERED.** We accept payment in the form of Cash and Visa/Mastercard/American Express/Discover. Also, if your insurance requires you to obtain referrals you must fill out a referral request form. Referral requests may take 48 hours to process. Your signature below signifies your understanding and willingness to comply with these policies.

DATE _____

PATIENT

SIGNATURE _____