Central Jersey Family Medical Group, P.A.
Dr. Jared B. Newman ~ Dr. Joseph A. Bordieri
333 Forsgate Drive
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Jamesburg, NJ 08831
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Acknowledgements

I have received the CJFMGPA patient handbook, which includes the following:

- Notice of Privacy Practices
- Patient Responsibilities
- Central Jersey Family Medical office policies

I understand I am to review this packet and abide by the policies within.
I also understand a copy of this packet is available to me at anytime upon request.

____ I acknowledge I have reviewed a copy of Central Jersey Family Medical Group HIPPA policies. I also understand a copy of this packet is available to me at anytime upon request.

Financial Responsibility

Please INITIAL below:

____ I hereby accept financial responsibility including but not limited to all co-payments, coinsurances, and payment of all deductibles and out of pocket expenses. I understand co-pays are due at time of service, to be paid by cash or credit card only (no AMEX accepted).

____ I hereby authorize the payment of health insurance benefits to CJFMGPA for services rendered. I hereby authorize CJFMGPA to release any health information necessary to complete and process my insurance claims.

____I understand that CJFMGPA may charge a $25 "no show" fee in the event that I do not call with at least 24 hours notice to cancel an appointment or a $50 "no show "fee for a missed physical not canceled within 48 hours.

By signing below, I acknowledge that I understand and agree to the above notices of financial responsibility and acknowledge the receipt of the handbook.

Name (printed):_____ Date of Birth: _____

Signature: _____ Date_____

Staff initials: _____