Bridge To Life Clinical Consultants, LLC Comprehensive Medical and Preventive Care

Name _____ Date of Birth _____
(First) (Middle) (Last) (MM/DD/YYYY)

SS# (Last 4 digits) _____ Sex M F Other _____ Marital Status S M W D

Preferred Language: _____

Race: (pls circle) Asian/Black or African American/ Hispanic/Native American/ White/Other _____

Email address _____

Home Address _____

Apt. # _____ City _____ State _____ Zip Code _____

Phone # Cell _____ Home _____ Work _____

Employer Name _____

Pharmacy (name and #) _____

Pharmacy Address _____

Emergency Contact (Name) _____

Emergency Contact Phone # and Relationship _____

Referral Source _____

PCP Name _____ Phone # _____

INSURANCE INFORMATION

Primary Insurance _____

ID# _____ Group # _____ Plan _____

Secondary Insurance _____

ID# _____ Group # _____ Plan _____

Subscriber _____ Relationship to Patient _____ DOB _____

Self Pay only (Circle one Method of Payment) Cash Check Debit/Credit HSA Card

I hereby give consent to receive appropriate medical care and treatment from Bridge To Life Clinical Consultants. I also agree to receive automated text, voice messages or email reminders of scheduled appointments and invoice statements including promotional offers at the phone numbers, mailing and email address listed above. I understand that I am financially obligated for payment of all services rendered. Should I default on payments for services deemed as my responsibility, I understand that collection efforts will be activated. No refund will be expected on my part or made once services are rendered and completed.

SIGNATURE _____ DATE _____

811 Washington Rd, Parlin, NJ 08859
203 Main Street, Matawan, NJ 07747
p: 848.444.1962
f: 848.900.8009
web: www.btlcc.org
email: info@btlcc.org

BRIDGE TO LIFE CLINICAL CONSULTANTS, LLC

Bridge to Life
CLINICAL CONSULTANTS

COMPREHENSIVE MEDICAL AND PREVENTIVE SERVICES

Covid-19 Pre-Screening Questionnaire

1. Do you currently have a fever >100.0?
   Yes **No**

2. Do you have a new onset (LESS THAN 14 DAYS) cough?
   Yes **No**

3. Do you have a new onset (LESS THAN 14 DAYS) shortness of breath?
   Yes **No**

4. Do you have a sore throat?
   Yes **No**

5. Do you have a new onset (LESS THAN 14 DAYS) loss of smell or taste?
   Yes **No**

6. Have you had a viral saliva/swab test?
   Yes **No** If yes, specify date and result:

If you answered yes to any of the above questions, someone from our office may ask you for additional pre-screening questions before your office consultation with the clinician.

All sick patients and visitors will be required to wear a mask before receiving services.

Bridge To Life Family Medicine remains open to see and treat patients.
We are strictly following the CDC's recommendations for cleaning and sanitizing our offices daily. Please be assured we are following best practices to keep our patients, staff, and practitioners safe so we may continue to serve our communities' needs effectively.

I acknowledge that I have read the above information and answered correctly by signing below.

PATIENT NAME: **DOB:**

Patient Signature: **Date:**

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BRIDGE TO LIFE CLINICAL CONSULTANTS, LLC

COMPREHENSIVE MEDICAL AND PREVENTIVE SERVICES

General Consent for Medical Care

I _____, hereby voluntarily consent to the rendering of such care including in-person or telehealth medical evaluation, physical examination, diagnosis, lab and diagnostic testing, counseling, treatment, vaccinations or procedures by the physicians, nurse practitioners or authorized designees of Bridge to Life Clinical Consultants, as may in their professional judgement be deemed necessary to provide care for me or my dependent minor.

In making medical decisions for treatment purposes, Bridge To Life Clinical Consultants may use or release your health information to other healthcare facilities and their staff, to third party payors and other third parties as necessary to obtain payment for services rendered to you or your dependent. Bridge To Life Clinical Consultants may also seek to obtain your electronic medical record and prescription medication history from other healthcare providers, third party pharmacy benefit managers or through the Health Information Exchanges, in order to provide health care services. For additional information regarding the use and disclosure of your health information please review our Notice of privacy Practices.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on my condition or that of my dependent minor and that I am responsible for all reasonable charges in connection with the care and treatment for myself and/or my dependent minor.

By signing below, I am confirming that I understand the above disclosures and consent to the treatment that I or my dependent minor named below will receive.

_____ _____

Patient Name Date

_____ _____

Signature Relationship

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BRIDGE TO LIFE CLINICAL CONSULTANTS, LLC

Comprehensive medical and primary care services

Office Financial Policies

By signing below, I acknowledge that I have had an opportunity to address any concerns about the information below with Bridge to Life Clinical Consultants (BTLCC) staff, either in person or by telephone conversation. I consent to the services being offered to me by BTLCC and I am satisfied with the explanation. I acknowledge that I have read or have had read to me the financial policies and understand the information presented. I agree to pay any fees incurred if the procedures below are not adhered to.

Payment is Expected at the Time of Service

- Payment is required at the time services are rendered. This includes applicable co-pays, co-insurance, deductibles and outstanding account balances. clients who have an outstanding balance must make arrangements for payment prior to scheduling follow up appointments.

- Payment can be made with cash, personal checks or any major credit card. If a personal check is returned for insufficient funds, we will charge a $35 fee and request an alternate method of payment.

- A surcharge of $10 will be applied for copayments and deductibles not paid on the date of service.

- Please note, missed appointments impact us negatively and signifies a cost to our office and other clients who could have been seen in the time set aside for you. We will apply a $25 surcharge to missed appointments (No call & no show). We understand emergency situations can occur and we will waive this fee for clients who call to cancel or reschedule their appointment within a reasonable time period of 12 hours or more before their scheduled visit time.

- A surcharge of $25 will be applied should you have two consecutive appointment cancellations.

- A surcharge of $10 will be applied for late show up of more than 15 minutes after scheduled visit times. Exceptions are allowed if you notify our office of a reason for delay at least 30 mins in advance.

- For clients using medical insurance, your insurance policy is a contract between you, your employer (if applicable) and your insurance company. You are personally responsible to understand how your policy works, including covered benefits for office visits, immunizations, and lab work. We will bill your insurance on your behalf, If we do not receive payment from your insurance company within 60 days from the date of service, you will be expected to pay the billed balance.

- It is the clients' responsibility to update their demographics and new insurance information with our office. We will send an invoice by email and/or mail to the address we have on file if your insurance denies coverage or reimburses less than the allowable charge. If your address is incorrect, or you do not receive an invoice, we will assume that you have been notified of the amount due from your explanation of benefit (EOB) sent to you from your insurance company.

Print Name	Signature	Date