390 Route 10 West, North Building Suite 102
Randolph, NJ 07869
Stuart H. Miller, M.D.

PATIENT INFORMATION

Patient Name: Last First: MI Nickname
Address: Street Apt #
City State Zip Code
Date of Birth: Home Phone #
Social Security # Work Phone #
Email Address Cell Phone #

- Please Indicate: Male Female Marital Status: Single Married Widowed Divorced Domestic Partner
- Race: African/American American Indian Asian Caucasian Native Hawaiian Other Refuse to Answer
- What is your preferred language?
- Please Indicate Ethnicity: Hispanic/Latino Not Hispanic/Latino Refuse to Answer
- Height: Weight:
- Referring Physician:
- Allergies or reactions:
- Please state your personal priority and goal for vein treatment:
- **Your Primary Doctor's Name**:
  Group Name:
  Address:
  Phone:
- **Your Pharmacy**
  Address:
  Phone:
- **Your Employer**
  Address:

Primary Insurance Information

Insurance Company
Patient ID # Group # Effective Date
Subscriber/Cardholder Name Subscriber DOB
Subscriber SS# Relationship to Patient
Address (if different from patient)
Phone #

Secondary Insurance Information

Insurance Company
Patient ID # Group # Effective Date
Subscriber/Cardholder Name Subscriber DOB
Subscriber SS# Relationship to Patient
Address (if different from patient)
Phone #

It is the policy of this practice that any fees or co-payments are due and payable at the time of each visit. By signing below, you agree to be financially responsible for all bills incurred that are not covered or paid by insurance, as determined by your insurance company, while receiving care at this office. As a courtesy, insurance billing is provided for all plans in which the practice is a participating member. We do not participate in NJ Medicaid and you will be balance billed for all costs after payment from primary insurance. By signing below, you agree that all insurance payments be made directly to Dr. Stuart H. Miller. It is the patient's responsibility to provide his/her current insurance card and obtain and keep current referrals for each visit and to notify us of all changes in coverage. There will be an additional $50 collection fee for all outstanding balances sent to an outside collection agency. The entire balance is the responsibility of the guarantor and delinquent accounts will be assessed at an interest rate of 1.5% monthly. If your account is turned over to collections, all costs incurred for collection, attorney, court, etc. will be your responsibility. By signing below, you authorize the use of this signature on all insurance submissions and on all legal submissions/medical records to an attorney, law enforcement representative and doctors or facilities that may also be involved in your medical care.

Signature Date
(if under 18 years of age, a parent or guardian must sign for patient)

Patient Responsibility
For Follow-Up Care Pledge

I, (please print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy treatment and/or outcome. I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medication shall by my sole responsibility (or my guardian who has attending this consultation). I agree to properly follow the prescribed dosage and frequency amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to another doctor or receive another test including, but not limited to: blood test, MRI, CT scan, this timely recommendation is important and essential to the ultimate success of my treatment and/or outcome. I understand that is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow the medical advice given by any medical person in this office. I also understand that any bad health outcome from my failure to follow the advice of my doctors should be expected.

Patient or Guardian Signature   Today's Date

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MEDICARE PATIENTS ONLY

"I request that payment of all authorized Medicare benefits be made either to me or on my behalf to this office for any services furnished by that physician to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services."

Patient (or authorized) Name

Patient (or authorized) Signature

Health Insurance Claim Number (Medicare ID)

Date