John Drulle, M.D.
Emilia Eiras, M.D.
702 Brewers Bridge Rd
Jackson, N.J. 08527
(732)905-9630

Patient Information

Patient Name: _____
Date of Birth_____ Age_____ Sex_____ Marital Status _____
Address _____
City _____ State _____ Zip Code_____
Home Phone _____ Work Phone_____ Cell _____
Soc. Security _____ Driver's Lic. # _____
Previous Doctor _____

If Minor
Parent / Guardian Name: _____
Address _____
Home Phone _____ Work Phone_____ Cell _____
Soc. Sec. _____ Driver's Lic. _____

Emergency Contact _____ Phone _____

Patient's Employer_____ Phone_____
Address _____ Ext _____ Hrs. _____

Who is responsible for the billing? _____
Today's method of payment: Cash _____, Check _____, Credit Card _____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

I have read all information on both sides of this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify this office of any changes in my status or the above information.

_____ _____
Signature *Date*

_____ _____
Parent (if minor) *Date*

Payment Policy

EACH PATIENT IS FINANCIALLY RESPOSIBLE FOR THE PAYMENT OF ALL SERVICES OR SUPPLIES PROVIDED AT THE TIME OF EACH VISIT.

This office does not participate with any Insurance Company (except Medicare).
Each patient will be provided with a receipt, commonly referred to as a "superbill".
This form meets the legal requirements of the Healthcare Financing Administration which mandates the use of the International Classifications of Disease, 9th revision, Clinical Modification (ICD-9-CM), As the medical coding system physicians must use to designate diagnosis and treatments. Further, this "superbill" can be attached to any of the healthcare claim forms and submitted for processing. This is entirely sufficient by law for reimbursement by your insurance company. It is the patient's responsibility to submit the claim to their insurance company for their reimbursement.

In regards to any monies that the Doctors receive on your behalf, including payments made directly by insurance companies, the Doctors have the right to deduct any and all monies due to them for services performed on your behalf.

Even though payment is due at the time of the visit, you still can receive an itemized bill from time to time for services not charged or not covered. Payment is required within 30 days. If payment is not received within 30 days, you will be charged a monthly rate of 1 ½ % on any balance due. Should any overdue balance have to be brought to collection, by lawsuit or otherwise, you will be responsible for all cost of collection, including attorney fees and Court cost.
If you fail to comply after 30 days of the original notification, the Doctors may withdraw from providing nay further treatment.
The Doctors will also withdraw any time at your request if you so desire.

Only Medicare will be submitted by this office

Insurance Information
#1 Name of Ins. _____
Plan Number _____ Group # _____
Subscriber's Name _____ Relationship _____

#2 Name of Ins. _____
Plan Number _____ Group # _____
Subscriber's Name _____ Relationship _____

I authorize payment of medical benefits directly to this physician and / or suppliers of medical services rendered.