Atlantic
Health System

PATIENT/FAMILY CONTACT COMMUNICATION

ONLY PERSONS LISTED ON THIS FORM MAY BE GIVEN DETAILED PATIENT INFORMATION.

COMMENTS: Date

UNIT REPRESENTATIVE:

PRIMARY CONTACT NAME:	RELATIONSHIP:
HOME #:	BUSINESS #:
CELL #:	BEEPER #:

OTHER PERTINENT INFO:

SECONDARY CONTACT NAME:	RELATIONSHIP:
HOME #:	BUSINESS #:
CELL #:	BEEPER #:

OTHER PERTINENT INFORMATION:

OUTPATIENTS

Designated phone number where a **secure detailed** message can be left: _____

Phone number where I can be reached **tomorrow (or the day after procedure),** for follow up: _____

PATIENT SIGNATURE:	TIME/DATE:

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INSURANCE REFERRAL INFORMATION

Last Name: _____ First Name: _____

☐ My insurance is MEDICARE and I do not need a referral.

☐ I have private insurance that **DOES NOT** require referrals.

☐ I have private insurance that **REQUIRES REFERRALS** be obtained prior to each office visit. I understand that I am responsible for obtaining referrals prior to each office visit and for office procedures. I also understand that I am responsible for payment in advance for any office visits or procedures for which a valid referral has not yet been obtained.

☐ I have private insurance that **REQUIRES REFERRALS** be obtained prior to each office visit. I do not have a valid referral for this visit DATE: _____ and I have chosen to pay in advance for the visit. The amount charged for this visit: $ _____.

☐ If a pessary is required as a treatment measure, you will be charged for the pessary in addition to visit charge.

Patient Signature: _____ Date: _____ Time: _____

Atlantic Urogynecology Associates
435 South Street, Suite 370 · Morristown, NJ 07960 · 973.971.7267
MAC I, 33 Overlook Road, Suite 409 · Summit, NJ 07901 · 908.522.7335

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CONSULT REQUEST FORM

Last Name: _____ First Name: _____

Today's consultation with ☐ Dr. Culligan ☐ Dr. Salamon

is the verbal request for consultation for _____
(patient name)

from Dr. _____.
(referring physician)

Patient/Legal Guardian Signature: _____

Date: _____

For office use only

S.R.

Time

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