NORTH JERSEY NEPHROLOGY ASSOCIATES, P.A.

Patient Registration Form

Referred by: _____

Name: _____ **S.S. Number:** _____

Address: _____ **Date of birth:** _____

City/State: _____ **Zip:** _____ **Home phone:** _____

Cell phone: _____ **Gender:** ___ **Male** ___ **Female** **Marital status: S M W D**

Ethnicity: Hispanic/Latino Not Hispanic/Latino **Race:** American Indian or Alaskan Native Black or African American Native Hawaiian or other Pacific Islander White Other_____

Employer Name: _____ **Phone No:** _____

Employer Address: _____ **City/State:** _____

****

Primary Insurance: _____

ID No: _____ **Group No.**_____

Insured's Name: _____ **Relation to Patient:** _____

Secondary Insurance: _____

ID No: _____ **Group No.**_____

Insured's Name: _____ **Relation to Patient:** _____

IF COVERED BY SOMEONE OTHER THAN YOURSELF, PLEASE FILL OUT INFORMATION BELOW

Subscriber's Name: _____

Subscriber's Employer: _____

Subscriber's date of birth: _____ **Subscriber's SS #:** _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize North Jersey Nephrology Associates, to apply for benefits on my behalf for covered services rendered by my family physician or by his/her order. I request that payment from my insurance company be made directly to North Jersey Nephrology Associates (or to the party who accepts assignment),

I certify that the information I have reported with regard to my insurance coverage is correct.

I agree and accept the terms of the North Jersey Nephrology Associates Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing,

Date: _____ **Signature** _____

NORTH JERSEY NEPHROLOGY ASSOCIATES, P.A.

Patient Record of Disclosure

I _____ give permission to the physicians and their staff at North
(Please print patient name)
Jersey Nephrology Associates to leave messages regarding my healthcare in the following manner when I am not available:

(Please check all that apply)

_____ May ONLY leave information with me. **(If you check here, no other choices should be checked)**

_____ May leave appointment reminders on my answering machine/voice mail.

_____ May leave appointment reminders with my family.*

_____ May leave lab results on my answering machine/ voice mail.

_____ May leave lab results with my family.*

_____ May leave general questions/information on my answering machine/voice mail.

_____ May leave general questions/information with my family.*

*if you choose to give our office authorization to speak to any family member(s), please list name of individual(s) we may give information to:

Name: _____ Relationship:_____

_____ I would prefer to be contacted at: _____ Home # _____

_____Work # _____

_____Cell # _____

_____Other # _____

_____ _____

Patient's Signature **DATE**

NORTH JERSEY NEPHROLOGY ASSOCIATES, P.A.

Financial Policy

We are committed to quality care. The following is a statement of our Financial Policy that we require you read and sign prior to any services rendered.

- **Patients are expected to present their insurance card at each visit and to notify our office of any changes in insurance.**
- **<u>Self Pay Patients(uninsured patients):</u> Full payment is due at the time of service.**
- **Co-pays are to be paid when services are rendered.**
- **We accept cash, personal checks and credit/debit cards.**
- **We offer an extended payment plan**
- **Usual and customary rates apply**

Our practice is committed to providing the best treatment of our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MANAGED CARE PATIENTS
It is your responsibility to know your insurance benefits. If your insurance requires referrals, please be aware that is YOUR responsibility to obtain one from your Primary Care Physician.
If you do not have a referral, please understand that you have the option of being seen, but you will be responsible for paying all charges.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____
Print Name

_____ _____
Signature of Patient or Responsible Party **DATE**

NORTH JERSEY NEPHROLOGY ASSOCIATES, P.A.

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent.
I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

NOTICE OF PRIVACY PRACTICES
(MEDICAL)
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:
treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your Insurance company for payment.
- Health care operations Include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures or protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting or disclosures or protected health information.
- The right to obtain a paper copy of this noticed from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of The Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures or our office. We will not retaliate against you for filing a complaint.

Please contact us for you more information: For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202)619-0257
Toll Free: 1-877-696-6775