

Bergen Family Practice of North Jersey

50 South Franklin Turnpike
Ramsley, New Jersey 07446
Telephone: (201) 934-0043
Fax: (201) 934-6217

PATIENT INFORMATION – PLEASE PRINT CLEARLY

Date: _____ Account # _____

Allergies to Medication (if any): _____

Name: _____

Last First M.I.

Address: _____

Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birth Date: _____ Social Security Number: ____ - ____ - ____
Month-date-year

Sex: ___Male ___Female Marital Status: ___Married ___Single ___Divorced ___Widowed

Pharmacy Name: _____ Pharmacy Number: _____

BILLING/INSURANCE INFORMATION

Person Responsible for Charges: _____

Last First M.I.

Street Address: _____ Phone #: _____

City State Zip

Relationship to Pt: _____ D.O.B. _____ S/S #: ____ - ____ - ____

Employer Name and Address: _____

Occupation: _____ Name of Insurance Company: _____

Policy/ID# _____ Group #: _____ Effective Date of Policy: _____

Claims Address: _____

Insurance Phone Number: _____

Primary Care Physician: _____ Other Health Insurance: _____

Policy/ID# _____ Group #: _____ Effective Date of Policy: _____

AUTHORIZATION

I hereby authorize Bergen Family Practice of North Jersey to furnish information to insurance carriers concerning my illness and treatments. I understand that I am responsible for any amount not covered by insurance. A copy of this authorization may be used in place of the original.

Signed: _____ Date: _____

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Notice of Privacy Practices Acknowledgment

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPPA”), 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 received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. 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 listed above 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.

Patient Name _____

Relationship to Patient _____

Signature _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient’s signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do as documented below:

Date: _____ Initials: _____ Reason: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE READ DOCUMENT CAREFULLY

The Health Insurance Portability & accountability Act of 1996 (HIPPA) 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. HIPPA provides penalties for covered entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of you 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, coordination or managing health care and related service by one or more health care provider. An example of this would include teeth cleaning services.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing and collection activities and utilization review. An example of this would be sending a bill 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 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 interest to you.

Any other uses and disclosures will be made only with you 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 of 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 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 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 of disclosures of protected health information.
- The Right to obtain a paper copy of this notice from us upon request.

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PATIENT CONSENT FORM

Patient: _____

Physician: _____

In connection with the medical services that I am receiving from the above-named physician or physician group, I hereby authorize the above-named physician and or group to disclose and/all information concerning my medical condition and treatment, including copies of applicable hospital and medical records to:

- A. Any third-party payer covering the medical services of the patient;
- B. Other health care professionals and institutions involved in the delivery of healthcare to the patient;
- C. The proponent of any legally sufficient subpoena, or in response to a court order;
- D. Employees and agents of the practice, may call my home or other alternative location and leave a message on voice mail or in person to facilitate the provision of healthcare services and payment for such services; such as appointment confirmation calls, insurance items and calls pertaining to my clinical care, including laboratory test results;
- E. Pharmacies; and
- F. Other parties as otherwise required by law.

In each case, the practice shall take reasonable steps to ensure that only the minimum necessary information is disclosed in accordance with the above. I further understand that I have been given access to the physician's privacy notice and I have had the opportunity to place special restrictions upon the consent hereby give:

Special Restrictions:

This consent is valid from the date executed until revoked in writing by the patient:

Signed: _____

Date: _____

Witness: _____

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Commercial Insurance Waiver

Many insurance companies are denying payments to physicians for services which the insurance company feel are either routine or for health screening purposes. These same insurance companies may also deny payment for services that they feel are not “reasonable and necessary” even though your doctor feels that they are reasonable and medically necessary.

By signing this waiver, you accept responsibility for any charges incurred from services rendered by the doctors of Bergen Family Practice of North Jersey that are not covered by your insurance company because of one or more of the above reasons.

Patient Name: _____

Signature of Patient: _____

Date: _____

Date of Birth: _____

Social Security #: _____ - _____ - _____