8.2-MTBC-F-10

A Unique Healthcare IT Company®

CONFIDENTIAL

NEEPA MERCHANT MD FAMILY PRACTICE, PA

REGISTRATION INFORMATION

PLEASE PRINT

◯ New Patient

◯ Existing Patient

Existing Patient: Revise all information that has changed since your last visit

DATE ___/___/_____ **EMAIL ADDRESS** _____ **HOME PHONE:** (___) ___-_____

CELL PHONE: (___) ___-_____

PATIENT'S NAME: _____ , _____ _____

LAST *FIRST* *MI*

STREET ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **RACE** _____

SSN: ___-___-___ **GENDER:** ◯ *M* ◯ *F* **BIRTH-DATE:** ___/___/_____

◯ *SINGLE* ◯ *MARRIED* ◯ *DIVORCED* ◯ *SEPARATED* ◯ *WIDOWED*

Preferred Language _____ **Ethnicity** _____

Patient Employed By : _____

Business Address: _____

Occupation: _____ **Business Phone:** (___) ___-_____

Name of Spouse/Responsible Party (If Patient is minor): _____ , _____ _____

LAST *FIRST* *MI*

Spouse/Responsible Party Employed by: _____

Business Address: _____

Occupation: _____ **Business Phone:** (___) ___-_____

RESPONSIBLE PARTY/SPOUSE SSN : ___-___-_____

DO YOU HAVE MEDICAL INSURANCE ? ◯ NO ◯ YES **If Yes:**

NAME OF PRI. INS. : _____ **ID #:** _____ **GRP #:** _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** ___/___/_____

ADDRESS OF PRI. INS. : _____

NAME OF SEC. INS. : _____ **ID #:** _____ *GRP #:* _____

***SUBSCRIBER'S NAME:** _____ ***BIRTH DATE:** ___/___/_____

ADDRESS OF SEC. INS. : _____

***Required by HIPAA**

◯ Pay my balance at the time of service ◯ Pay my balance upon receipt of first statement ◯ Make payment arrangement prior to rendering of services.

In case of emergency, who should be notified? _____ Relationship _____

Person authorized to receive PHI _____ Relationship _____

PHONE: (___) ___-_____

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I, _____ hereby authorize _____

(NAME OF INSURED) (NAME OF INSURANCE COMPANY)

to pay and hereby assign directly to _____ all benefits, if any, otherwise payable to

(PROVIDER'S NAME)

me for his/her services as described on the attached forms. I understand I am financially responsible for charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____

(PROVIDER'S NAME)

will be credited to my account, in accordance with the above said assignment.

Neepa Merchant MD Family Practice, P.A.

Notice of Privacy Practices

Our commitment to your privacy: By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time. We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your Privacy rights in your PHI
- Our Obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any Revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our most current Notice at any time. If you have questions about this Notice, please contact our office by Phone and please ask to speak with our HIPPA Compliance Officer in person.

We may use and disclose your PHI in the following ways:

1. **Treatment**. Many of the people who work for our practice-including, but not limited to, our doctors and nurses- may use or disclose your PHI in order to treat you or to assist others in your treatment. We may disclose your PHI to other health care providers for purposes related to your treatment.
2. **Payment**. Our Practices may use and disclose your PHI in order to bill and collect payments for the services and items you may receive from us.
3. Disclosures required by law. Our practice will use and disclose your PHI when we are required to do so by federal, state, or local law.

Use and disclose your PHI in certain special circumstances:

1. Public health risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    - Maintaining vital records, such as births and deaths
    - Reporting child abuse or neglect
    - Preventing or controlling disease, injury or disability
    - Notifying a person regarding potential exposure to a communicable disease
    - Reporting reactions to drugs or problems with products or devices

- Notifying individuals if a product or device they may be using has been recalled

2. Health Overnight activities. Our Practice may disclose your PHI to a health oversight agency for activities authorized by law.
3. Lawsuits and similar proceedings. Our Practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.
4. Serious threats to health or safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.
5. Military. Our Practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. National Security. Our Practice may disclose your PHI to federal officials for intelligence and national security activities authorized by the Law.

Your rights regarding your PHI:

1. Confidential communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location.
2. Requesting restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.
3. Inspection and copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records.
4. Amendement. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice.
5. Accounting of disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for purposes not related to treatment, payment or operations.
6. Right to a paper copy of this notice. You are entitled to receive a paper copy of our notice of privacy practices.
7. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the secretary of the Department of Health and Human Services.
8. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

Print Name: _____ Signature: _____

Date: _____

FINANCIAL POLICY

Patient Name_____

Date of Birth_____

ALL PAYMENTS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. Neepa Merchant MD Family Practice accepts cash, personal checks (in-state only), VISA, Discover, Diners Club International, ICB, and MasterCard. There is a service charge for returned checks. Patients with an outstanding balance 60 days or more overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE:

We bill participating insurance companies, you are expected to pay your copayments at the time of service. You are responsible to be sure all charges are paid whether by you or by your insurance carrier.

NON-COVERED SERVICES:

Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

COLLECTIONS:

Any fees or surcharges imposed by a collection agency will be your responsibility, along with the full outstanding balance from your visit.

I Have read and understood the Neepa Merchant MD Family Practice Financial Policy. The patient is ultimately responsible for all professional fees.

Signature of insured or Authorized Representative: _____

Date: _____

Relationship, if minor: _____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD

Date of Request: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____
(Month/Day/Year)

Address: _____

_____

City State Zip Code

Phone Number: _____

I hereby authorize disclosure of my Medical Records:

From: _____

_____

_____

To:

Neepa Merchant MD Family Practice, P.A.
378 South Branch Road, Suite 302
Hillsborough, NJ 08844
Phone: 908-290-0404
Fax: 908-933-0954

_____ _____

Patient's Signature Date