North Jersey Diabetes and Endocrinology

Center of Diabetes, Endocrine and Metabolic Disorders

Date:_____

Patient

Last: _____First:_____Middle Initial: ___

Address: _____City:_____State:_____ZipCode:_____

Social Security #:_____-_____-_____Date of Birth: ____/_____/_____

Sex: Male / Female

Marital Status: ____

Best Contact Phone #:_____ Alternate Phone#: _____

Email: _____@_____. com

Incase of Emergency

Name of Emergency Contact:_____ Relationship To emergency contact:_____

Emergency Contact Phone #:_____

Insurance Information

(Please present ALL insurance cards to the front desk)

Guarantor information: (*Who is the insurance policy holder?*)

Insured: Self: _____Spouse :_____ Other _____

If not self please provide:

Name:_____ DOB:_____

Additional Information:

Primary Care Doctor: _____

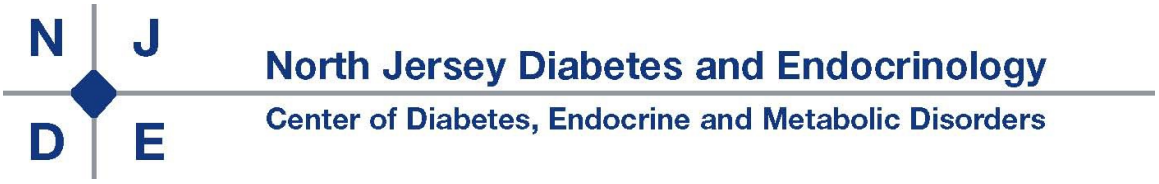
Pharmacy Name: _____

Pharmacy Location: _____ Pharmacy Phone (Optional) #_____

"I request that payment of Medicare or other insurance benefits be made on my behalf to Merab Joseph, MD for any services furnished me by Merab Joseph, MD or his designees, I understand that I will be responsible for any fees, deductibles, copayments and non-covered services. I authorize any holder of medical information about me to be released to my insurance carrier and its agents in order to determine benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature X_____Date:_____

(Patient/ Guardian) Form DM32471fp



Office Payment Policy

Please Read Carefully!

_____

Thank you for choosing us as your provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.**

2. **Co-payments and Deductibles. All Co-payments and Deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.**

- **What is a Deductible? The amount you pay for covered health care services before your insurance plan starts to pay. For example, with a $1,000 deductible, you pay the first $1,000 of covered services yourself. After you pay out your deductible, you usually pay only a copayment or coinsurance for covered services. Your insurance company pays the rest.**

3. **Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.**

4. **Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is**

your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.**

6. **Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice.**

7. **Missed appointments. Our policy is to charge for missed appointments $25.00 not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.**

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party/Date

Print Name:_____

Signature X :_____

Date:_/_/___

N J
D E

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Merab Joseph, M.D., F.A.C.E.

PATIENT'S PAYMENT AUTHORIZATION FOR CO-PAYS, CO-INSURANCE,

DEDUCTIBLE AND NON-COVERRED SERVICES:

I have read and understand my financial responsibilities as stated above and hereby authorize _____ to charge my credit card for and co-pays, co-insurance, or deductibles amounts exactly as they are assigned to me by my insurance carrier; as in my claims Explanation of Benefits.

MasterCard _____ Visa _____

Name as it appears on the card: _____

Card Number _____ Exp. Date: _____ CVV# _____

Your Signature _____ Date: _____

_____ Check Here if you would like a receipt/statement upon processing

_____ Check Here if you would like us to call before processing transaction

596 Anderson Ave. Suite 208, Cliffside Park, NJ 07010
Tel: 201-941-5757 Fax: 201-941-5779

24-07A Broadway, Fair Lawn, NJ 07410
Tel: 201-796-4600 Fax: 201-796-4666

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Authorization to Release Information to Others

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This consent form will not allow North Jersey Diabetes and Endocrinology to release any other information to these family members. This authorization shall be in effect upon signing this form.

You have the right to revoke this consent in writing.

I authorize/allow North Jersey Diabetes and Endocrinology to release my medical and/or billing information to the following individual(s):

1._____Relation to Patient: _____

2._____Relation to Patient: _____

3._____Relation to Patient: _____

You have the right to revoke this consent in writing.

Patient Name: _____

Patient Signature: _____ **Date**:__/__/_____

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.

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we will ask you for special written permission.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

· when a state or federal law mandates that certain health information be reported for a specific purpose;
· for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
· disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
· uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
· disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
· disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
· disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
· uses or disclosures for health related research;
· uses and disclosures to prevent a serious threat to health or safety;
· uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
· disclosures of de-identified information;
· disclosures relating to worker's compensation programs;
· disclosures of a "limited data set" for research, public health, or health care operations;
· incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
· disclosures to "business associates" who perform health care operations for us and who commit

to respect the privacy of your health information;
Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

APPOINTMENT REMINDERS

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

OTHER USES AND DISCLOSURES

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.
If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

The law gives you many rights regarding your health information. You can:

· ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.

· ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

· ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

· ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

· get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

· get additional paper copies of this Notice of Privacy Practices upon request. It does not matter

whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

Signature below is only acknowledgement that you have received this notice of Privacy Practices:

Print Name:_____

Signature X: _____

Date:_____