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370 Grand Avenue, Suite 102, Englewood, NJ 07631 • (201) 567-3370 • Fax: (201) 816-1265

Welcome!

PATIENT INFORMATION

Patient's Name:	Patient's Date of Birth:	Patient's Social Security Number:
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Marital Status (check): <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Patient's Sex (check): <input type="checkbox"/> Male <input type="checkbox"/> Female
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Permanent Address

Street: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Fax #: _____ Cell #: _____ E-Mail Address: _____

Mailing Address

Name: _____ C/O _____

Street: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

In Case of an Emergency, Contact

Name: _____ Relationship: _____

Street: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Patient's Occupation: _____ Employer's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Work Phone #: _____

Pharmacy Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Do you have any allergies? Please list: _____

Who referred you to this office? _____

Your other Doctors' names: _____

Are you here because of an (check one): Auto Accident Yes No Workman's Compensation Case Yes No

Patient is full time student Patient is part time student

(over please)

INSURANCE INFORMATION

PRIMARY Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Primary Care Doctor's Name: _____

Who owns this insurance policy? (Name of owner) _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Date of Birth of Policy Owner: _____ Social Security Number of Policy Owner: _____

Relationship of Policy Owner to Patient (check one): Self Spouse Child Other _____

SECONDARY Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Primary Care Doctor's Name: _____

Who owns this insurance policy? (Name of owner) _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Date of Birth of Policy Owner: _____ Social Security Number of Policy Owner: _____

Relationship of Policy Owner to Patient (check one): Self Spouse Child Other _____

TERTIARY (THIRD) Insurance

Name of Insurance Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Primary Care Doctor's Name: _____

Who owns this insurance policy? (Name of owner) _____

Address: _____

City: _____ State: _____ Zip Code: _____ Telephone #: _____

Date of Birth of Policy Owner: _____ Social Security Number of Policy Owner: _____

Relationship of Policy Owner to Patient (check one): Self Spouse Child Other _____

Please understand that you will be responsible for full payment of your bill if you have a deductible on your insurance plan or if you do not notify us at the time of your visit of your current insurance information.

PRIVATE Insurance Authorization for assignments of benefits/information release

I authorize the release of medical information necessary to process claim forms and the payment of medical benefits to named provider for medical services rendered. A copy of this authorization shall be valid as the original.

Patient, Parent or Guardian Signature (if Patient is under 18 years of age)

Date

Printed Name

MEDICARE Lifetime Signature on File

I authorize any holder of my medical or other information to release to the Social Security Administration and Health Care Financing Administration or its intermediaries any information needed for this or any other related MEDICARE claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to MEDICARE assignment of benefits apply.

Patient Signature

Date

Printed Name

OUR FINANCIAL POLICY

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

NEW PATIENTS OR PATIENTS WITH A CHANGE OF ADDRESS OR INSURANCE POLICY MUST FILL OUT A PATIENT INFORMATION FORM PRIOR TO SEEING THE DOCTOR.

WE WILL NEED TO PHOTOCOPY YOUR INSURANCE CARD (S) FOR YOUR FILE.

. COPAYMENTS - By law we MUST collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit.

. NON-COPAY PLANS - If your plan does not require a copay and we participate, we will accept the designated fee. You are responsible for any deductible and balance your plan indicates on their explanation of benefits.

. NON PLAN PATIENTS - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit. Your itemized receipt should be attached to your insurance form and sent to your carrier who will reimburse you directly.

. MEDICARE - We will submit to Medicare for the Medicare allowed amount. The patient will be responsible for the deductible and the 20% co-insurance which can be billed to secondary insurance if you have one.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT.

WE ACCEPT CASH OR CHECKS.

THANK YOU FOR TAKING THE TIME TO REVIEW OUR POLICIES. PLEASE FEEL FREE TO ASK ANY QUESTIONS OR SHARE WITH US ANY SPECIAL CONCERNS.

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

HIPAA Notice of Privacy Practices

Harvey R. Gross, MD, PC

370 Grand Avenue
Englewood, NJ 07631
(201) 567-3370
Fax: (201) 816-1265

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law .

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

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

Print Name: _____ Signature _____ Date _____