HIGHLAND PARK FAMILY PRACTICE, LLC

ARTHUR H. MILLER MD, FAAFP

505 RARITAN AVENUE
HIGHLAND PARK, NJ 08904
TEL: 732-393-1331
www.hpfamilypractice.com

PATIENT INFORMATION:

Patient's Name (Last)______________________________(First)____(Middle)_____________

Address____________________________________ City __________________________ State__________ Zip Code___________________

Gender: M/F_____________ Martial Status ___________________________ Ethnic Group ___________________________

Social Security# _________________________Birth date______________________ Email____

Home Phone______________________________Cell#____________________________ Work#__________________________Ext_____

Occupation_____________________ Employer___________________________________ City _____________________State________

Zip Code___________________________

RESPONSIBLE PARTY: (Guarantor)

Guarantor's Name (Last) ______________________________ (First) ____

Address____________________________________ City __________________________ State__________ Zip Code___________________

Home Phone_______________________________Cell#_____________________________ Work#_________________________________

Patient Relation to Guarantor________________________________ Guarantor Employer_______________________________________

Employer's Address_______________________________________ City, State, Zip____

Guarantor's SS#____ Guarantor's Birth date_______________________ Gender: M/F____

PRIMARY INSURANCE INFORMATION:

Name of Insurance Company____ Name of Policyholder____________________________

Pt. Relationship to Policyholder______________________ Policy/Id #____________________ Group# _____________________________

Insurance Co. Address____

Insurance Co. Phone #____________________________________ Policyholder Birthday_________________________ Gender: M/F___

Policy Holder Street Address __________________________ City _____________________________ Zip Code ____________________

Policy Holder's Phone# ________________________ Policy Holder's SS _______________________

SECONDARY INSURANCE INFORMATION:

Name of Insurance Company____ Policyholder___________________________________

Pt. Relationship to Policyholder______________________ Policy #_______________________ Group# ____________________________

Insurance Co. Address____

Insurance Co. Phone #____________________________________ Policyholder Birth date_________________________ Gender: M/F___

IN CASE OF EMERGENCY:

Name of Local Friend or Relative (not living at the same address)

____ Relationship to Patient ____

Home Phone #____ Work # ____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Highland Park Family Practice, LLC or insurance company to release any information required to process my claims. I consent to treatment for the care of the above patient.

____7/12

Patient/Guardian Signature Date

Patient Name ___________________

Medical History

1. Do you have any allergies to any medications, X-rays, dyes or other substances
Name Medication if yes____
____

2. Please list all the medications you are currently taking:
____
____
____
____

3. What Pharmacy do you use:____

4. Please list and supply dates of any operations:
____
____
____

5. Family History – Has Any member of you family ever had the following:

	Family Member	Age of Diagnosis
Cancer		
High Blood Pressure		
Diabetes		
Strokes		
Mental Illness		
Bleeding Diseases		
Drug or Alcohol Abuse		

PERSONAL HISTORY

Diabetes	**Yes**	**No**
Cancer	**Yes**	**No**
High Blood Pressure	**Yes**	**No**
Heart Trouble, Palpitations	**Yes**	**No**
Lungs	**Yes**	**No**
Bronchitis, Pneumonia, T.B.	**Yes**	**No**
Asthma. Hayfever, Sinusitis	Yes	No
Liver Problem, Jaundice, Hepatitis	**Yes**	**No**
Kidneys, Bladder, Urinary	**Yes**	**No**
Skin Disorder	**Yes**	**No**
Thyroid, Endocrine, Lymphatic	**Yes**	**No**
Epilesy, Seizures	**Yes**	**No**
Migraines, Headaches, Dizziness	**Yes**	**No**
Stroke	**Yes**	**No**
Emotional/Mental Illness	**Yes**	**No**
Anemia Blood Disorders	**Yes**	**No**
Back Disorders	**Yes**	**No**
Eye, Ear, Nose, Throat	**Yes**	**No**

The Last time You Had A:

	YEAR
FLU Vaccine	_______
Tetanus Shot	_______
Hepatitis Shot	_______
Pneumonia	_______
T.B.	_______
Stool Blood Test	_______
Eye Exam	_______
Dental Exam	_______
Cholesterol Exam	_______

Do you drink alcohol?……………………..Yes No **If yes, what kind?**_______________________
How many drinks per week? ____________
Do you use tobacco?………………………Yes No **How many cigarettes/cigars per day**_______
Do you currently use recreational or street drugs?………………………………Yes No
Have you ever given yourself street drugs with a needle?………………………..Yes No

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PROFESSIONAL SERVICES POLICY

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services.

Prompt payment allows us to control costs. Outstanding accounts cost both us time and money: therefore, all patients will be required to establish financial arrangements for payment of their account.

By law all patients' accounts are due and payable within 30 days of services rendered. As a courtesy, our practice will establish a reasonable monthly/weekly payment plan to accommodate your needs. All new patients will be required to remit full payment to establish an account.

It should be mentioned that your insurance coverage is an agreement between you and your insurer. It is your responsibility to remit payment for charges not covered by your claim and insure your carrier remits payment. If a problem occurs with your claim, you will be required to establish written financial arrangements with our practice until your insurance problem is resolved.

Each month you will receive a monthly statement for services, which is due and payable within 15 days. If your payment is late, or if you have not previously made financial arrangements, then we will mail a reminder notice or call you indicating there is a problem with your account. If you are experiencing a set of circumstances out of your control, please call our practice and we will be happy to make special arrangements.

All patients refusing to remit payment after 61 days of notice without pending insurance or financial arrangements will force us to limit their future credit until the previous balance is paid in full or written financial arrangements are accomplished. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if a mistake appears on the statement.

You may be asked to sign a waiver of liability for a particular service (i.e. EKG, Complete Medical Examination, minor surgery, etc.) that may or may not be covered by your insurance. This will be done to avoid any confusion regarding payment for a service that you may be required to pay.

Please read your insurance policy. Most patients do not know what their policy covers. Please inform yourself about the particulars of your insurance coverage. Every plan is different. We do not know what your coverage is until the service is rendered, billed and processed by your insurance carrier. This will avoid any surprise bills for non-covered services, deductibles, coinsurance, and/or co-pays due and payable by the patient.

I have read the above policy.
Patient's Signature_____________________

HIGHLAND PARK FAMILY PRACTICE
NOTICE OF INFORMATION

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU CAN BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

- There are legal requirements that require us to protect the privacy of patient's Personal History Information (referred to as PHI from this point on in this notice). There are legal requirements that require us to provide a Notice of Information and abide by the terms of the Notice of Information.
- Highland Park Family Practice (referred to as HPFP in this notice) will not use or disclose a patient's PHI for purposes not listed in the Notice of Information without the patient's authorization.. A patient can authorize a disclosure of their PHI, by requesting an Authorization for Disclosure from our staff. Disclosures are subject to the patient's control, and the patient may revoke the authorization.
- We will disclosure a patient's PHI without patient authorization for treatment, payment or healthcare operations only. Permitted disclosures include but are not limited to; emergency circumstances; identification of the body of a deceased person, or the cause of death; public health needs; research, generally limited to when a patient has previously agreed to participate in a pharmaceutical drug trial; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.
- We will leave messages on a patient's answering machine regarding billing matters, or to make patient aware that test results are available, or to remind a patient of an upcoming appointment. Patients have the right to opt out of these phone messages by requesting this in writing on the consent form.
- Patients have a right to request restriction of certain uses and disclosures of their PHI. HPFP is not required to agree to such a request. Patients may restrict certain uses and disclosures of their PHI on the consent form each patient will be required to sign.
- Patients are required to sign consent. If a patient refuses to consent to the use or discloses of their PHI to carryout treatment, payment or health care operations, HPFP may refuse to treat patient.
- Patients have the right to access their PHI for inspection and copying. There is a copying charge of $.50 per page. Patients may make an appointment with the Privacy Officer to inspect their PHI. Requests for an appointment may be made with the receptionist.
- Individuals have the right to an accounting of any disclosures of their PHI (consulting physicians, HMO's, labs, etc.)
- Individuals have the right to request an amendment or correction of PHI.
- An individual may request and complete an amendment form obtained from the Privacy Officer. (Patient histories in chart cannot be changed unless making a correction.)
- HPFP may revise our policies and procedures with respect to the uses or disclosures of PHI at any time, and that revision could result in additional uses and disclosures without the individual's authorization. That revision will also be updated and posted in our office in this Notice of Information and be indicated by highlighting any new policy or procedural changes. Patients may request a copy from the receptionist
- Patients have the right to complain the HPFP and o the Secretary of DHH if they believe their privacy rights have been violated. They may notify the Privacy officer in this office of their complaint or by calling 732-393-1331 and asking to speak with the Privacy Officer (Liz Tesi).
- This notice was created on March 3, 2002. Amended on 02/01/2010

Highland Park Family Practice, LLC,
505 Raritan Ave., Highland Park, NJ
ARTHUR H. MILLER, MD FAAFP

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that H.P.F.P. (Highland Park Family Practice, LLC) reserves the right to change their notice and practices and will post any revisions in this office, highlighting any changes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that H.P.F.P. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except o the extent that the organization has already taken action in reliance thereon.
I request the following restrictions to the use or disclosure of my health information.

____
Signature of Patient of Legal Representative Date

____
Witness

Notice Effective Date or Version______________________________

Accepted Denied ____
Signature Title Date

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ARTHUR H. MILLER MD, FAAFP
505 RARITAN AVENUE
HIGHLAND PARK, NJ 08904
TEL: 732-393-1331
FAX: 732-393-0575

DATE:

MEDICAL RECORDS RELEASE AUTHORIZATION

From:____
Name of Doctor or Hospital

____
Street Address

____
Town or City State Zip Code

I hereby authorize and request you to release a complete copy of my medical records, including test results.

To: Dr. Arthur Miller
505 Raritan Ave.
Highland Park, NJ 08904

Patient Information:

Name:_______________________________________D.O.B.___________

Address:____

____

SIGNATURE_______________________________
Circle One Self Spouse Child

Highland Park Family Practice, LLC
Arthur H. Miller, MD, FAAFP
505 Raritan Avenue
Highland Park, NJ 08904
732-393-1331

MEDICARE PATIENTS

We are a participating provider for Medicare. In order to clarify any confusion about coinsurance due and services not covered by Medicare please read the following.

Please read your Medicare handbook.

Medicare does not cover Annual Preventive Medical Examinations. You the patient is therefore responsible for all charges associated with any Annual Medical Examination sometimes referred to as a Complete Physical Examination (CPE).

However, Medicare does allow payment for medical conditions concurrently addressed during the CPE. Medicare allows us to bill them for that portion of the visit, which will reduce the balance of your annual physical exam charge. Therefore, you will receive a bill for the balance, which becomes your responsibility. Because of the extended time involved in taking a thorough history and performing and extensive physical examination the fees are higher than our average office visit fee.

All Medicare patients have an annual $155 deductible starting on January 1st of each year. You the patient are responsible to pay the first $155 billed to Medicare for medical services each year. We will bill you for any deductible that is not paid by your insurance company.

All Medicare patients are responsible and required to pay 20% of the Medicare allowable fee for any Medicare covered service performed in our office. If you have a secondary insurance that is a crossover from Medicare, we will await for payment from that carrier. If that carrier does not pay, you will be billed for the 20% due.

We do not submit to secondary insurance companies that do not crossover from Medicare. You will be responsible to make payments directly to our office for any amount due by you within 15 days of receipt of our bill. You may submit to your secondary insurance company for possible reimbursement.

Our practice firmly believes that a good doctor/patient relationship is based upon understanding and open communications. If you have any questions please feel free to ask any of our staff. We will make ourselves available to you in order to clarify any misunderstanding you have concerning your balance.

I have read the above statement.
Patient signature___________________________________