Patient Record of Disclosures

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

In order to provide accurate medical treatment we will need to contact you with instructions. Please provide *two* telephone numbers where we can speak with you or leave a detailed message for you.

Home (____) _____ **Work** (____) _____

Cell (____) _____ **Other** (____) _____

_____ _____

Patient Signature **Date**

_____ _____

Print Name **Birth date**

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided, if completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Please list names and numbers of any immediate family member to which you are allowing us to discuss medical conditions with.

Name	Telephone #	Relationship to Patient
1.		
2.		
3.		

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

PATIENT ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information ("PHI") about you. You have the right to review our Notice and ask questions about our policy practices. As provided in out Notice, the terms of our Notice may change. If we change our Notice, you may obtain a copy by the methods described within the Notice.

You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form you acknowledge that you have received our Notice of Privacy Practices.

_____
Name of Patient

_____
Signature of Patient

_____
Date

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Patient Information

Name _____ Date of Birth _____ Age _____
(Last) (First) (MI)

Address _____ Home Phone (____) _____

City _____ State _____ Zip _____ Cell Phone (____) _____

Social Security # _____ E-mail address _____

Local Pharmacy _____ Pharmacy Phone (____) _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Partner/Spouse Name _____ Date of Birth _____

Partner/Spouse Social Security # _____ Date of Birth _____

Referring Physician _____

Emergency Contact _____ Phone (____) _____

Relationship to patient ☐ Spouse ☐ Parent ☐ Other _____

Employment Information:

Patient

Employer _____ Phone (____) _____

Address _____

City _____ State _____ Zip Code _____

Employed: ☐ Full Time ☐ Part Time ☐ Seasonal ☐ Self-Employed

Insurance Information: *It is the patient's responsibility to provide any and all insurance and/ or prescription information

Primary

Insurance Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number _____

Guarantor: ☐ Self ☐ Other- Name _____

If other than self:

Social Security # _____ Date of Birth _____

Prescription Information: *It is the patient's responsibility to provide any and all insurance and/ or prescription information

Prescription Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number _____

Secondary Insurance

Insurance Carrier _____ Co-pay Amount _____

Policy Number _____ Group Number _____

Guarantor: ☐ Self ☐ Other-Name _____

If other than self:

Social Security # _____ Date of Birth _____

Please Note: All patients are responsible for annual deductibles, co-pays and/or any co-insurance amounts as assigned by your insurance carrier. All self-pay patients are required to pay for services on the date rendered.

I hereby authorize my insurance benefits to be paid directly to University Reproductive Associates, P.C. for all services rendered. I also authorize the release of any medical information to my insurance carrier concerning my care/ treatment. I understand that I am financially responsible for any fees, deductibles, co-payments and any non-covered services that may apply as directed by my insurance plan.

Patient/Guarantor _____ **Date** _____

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Patient Name: _____

1. **CONSENT TO CARE:** I wish to be treated by **University Reproductive Associates, P.C.** While I am a patient, I give permission to my doctor(s), the office employees, and all the persons caring for me to provide care in ways they judge are beneficial to me. I understand that this care may include tests, examinations and medical treatments. I understand that no guarantees have been made to me about the outcome of this care. **I understand that the University Reproductive Associates office is a teaching facility and that under the appropriate supervision medical students, residents and fellows may participate in my care and treatment.**

2. **RELEASE OF INFORMATION:** **University Reproductive Associates** may see, release to and/or confirm, all or part of any financial and medical information, **including information regarding psychological, psychiatric, HIV and related diagnoses, drug and/or** alcohol **related illness,** with any person, corporation or government agency that is or may be responsible to the office, the patient, and family member or employer for all or part of URA charges. I acknowledge that the Medical Center may require to release patient information, **including the highlighted above,** to federal and state agencies that monitor healthcare facilities, as well as any industries that produce and/or manufacture medical products. I acknowledge that URA may access patient information from my medical record for purpose of research. I acknowledge that I have been informed that I may be contracted to participate in a research study and that I have the right to agree or decline to participate.

3. **PATIENT RIGHTS:** **University Reproductive Associates has posted a copy of the New Jersey Bill of Rights** for my viewing, a copy will be given upon my request.

4. **PRE-CERTIFICATION REQUIREMENTS:** I understand if I do not comply with my insurance policy pre-certification requirements or if any service is not certified, that I may be responsible for any and all facility charges.
Please check the appropriate box: (Pre-Certification) I acknowledge that the pre-certification requirements I am responsible for have all been met. □ **Yes** □ **No** □ **N/A**

5. **ASSIGNMENT OF BENEFITS:** I authorize my health insurance benefits to be paid directly to **UNIVERSITY REPRODUCTIVE ASSOCIATES, P.C.** Under the terms of my policy this payment may not exceed the balance due for services performed during this period of treatment.

6. **FINANCIAL AGREEMENT:** When billed I agree to make prompt payment to University Reproductive Associates for any and all charges not paid by insurance benefits. I will also be charged a $25.00 fee for any bounced checks plus the amount of the check and the $25.00 bank fee. In addition, I agree, in order for University Reproductive Associates to service my account or to collect any amounts I may owe, they may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. Methods of contact may include using pre-recorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

7. **DEPOSIT REQUEST:** A deposit has been requested of me because I will be paying for all and/or part of URA bill.

8. **MEDICARE PAYMENT REQUEST:** I certify that the information given by me in applying for payment under Title XVM of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare Claim. I request that direct payment of authorized benefits be made on my behalf. I assign benefits payable for physicians' services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment.

THE SERVICE YOU RECEIVE MAY NOT BE COVERED BY YOUR MEDICARE INSURANCE, IN THIS EVENT; YOU WILL BE RESPONSIBLE FOR ALL CHARGES NOT COVERED.

I have read the information, any questions I had have been answered, and I understand its contents.

_____ _____
Patient Date

_____ _____
Guarantor (if other than Patient) Date

_____
Relationship of Guarantor to Patient (if applicable)

Revised 9/27/19