PATIENT REGISTRATION FORM

Doctor_____

P #_____

PATIENT INFORMATION

Patient Name: _____
Last First Middle Initial

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex ☐ M ☐ F Social Security #: _____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced - Spouses Name: _____

Race: ☐ White ☐ African American ☐ American Indian ☐ Asian ☐ Hawaiian/Pacific Is. ☐ Declined

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Employer:_____
Name and Address of Your Employer

Pharmacy: _____ Pharmacy Phone #: _____
Name / City

Who may we thank for referring you? _____

In case of emergency who should we notify?_____

Relation to Patient: _____ Daytime Phone # _____ Evening Phone # _____

GUARANTOR INFORMATION

Party Responsible: _____Relation to Patient: _____

Address: _____Phone #: _____
If different from Patient

PRIMARY INSURANCE

Please present your Insurance ID card and Driver's License to receptionist for photocopying

Insurance Company: _____ ID #: _____

Primary Subscriber: _____Date of Birth: _____ Social Security #_____

SECONDARY INSURANCE

Is Patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company: _____ ID #: _____

Primary Subscriber: _____Date of Birth: _____ Social Security #: _____

ADDITIONAL INFORMATION

Was this condition related to a work injury? ☐ Yes ☐ No

Was the injury reported to your Employer? ☐ Yes ☐ No

Was this condition related to a motor vehicle accident? ☐ Yes ☐ No

PAYMENT IS EXPECTED AS SERVICES ARE RENDERED

I hereby authorize the release of any medical information necessary in the processing of my insurance claims. I certify that the above information is complete and correct to the best of my knowledge.

Signature: _____ Date: _____

HEIGHTS MEDICAL
TODAY'S FAMILY PRACTICE SPECIALIZING IN YOU

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

And

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVATE PRACTICES

With my consent, Heights Medical may use and disclose protected health information about me to carry out treatment, payment and healthcare operation. (TPO) Please refer to Heights Medical's Notice of Privacy Practices (April 1, 2012) for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Heights Medical reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained online or by forwarding a written request to Dr. Bellavia at 288 Boulevard, Hasbrouck Heights, NJ 07604.

With my consent, Heights Medical may mail, E-Mail or call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

We will use or disclose your health information for the purposes described unless you notify us that you object to a particular use or disclosure. Your notification that you object to a particular use or disclosure is the exercise of your right to "Opt Out". To Opt Out you may inform the HEIGHTS MEDICAL Office Manager.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Heights Medical may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Patient's Name

_____

Print Name of Legal Guardian

HEIGHTS MEDICAL
TODAY'S FAMILY PRACTICE SPECIALIZING IN YOU

Patient Name_____

PERSONAL HEALTH INFORMATION PERMISSION

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act – HIPPA. This Federal Law prohibits any staff member of Heights Medical from discussing appointments, medications, test results or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for or about them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are a college student away at school and your parents assist you with prescriptions and appointments.

The law provides that you can permit one or more individuals to discuss your medical condition, confirm appointments or obtain results on your behalf. Below is a list which you may complete. Only those individuals listed may obtain information about you.

Please circle the following methods we may use to contact you:

You may leave a message:	Regarding Appointments	Regarding Medical Information	Phone #
Answering Machine at home	Yes/No	Yes/No	
With anyone at home	Yes/No	Yes/No	
Work Phone	Yes/No	Yes/No	
Cell Phone	Yes/No	Yes/No	
E-Mail	Yes/No	Yes/No	

Heights Medical Staff may discuss my medical file with the following:

Name of Individual	Relationship to Patient	Phone Number

Our e-mail complies with all HIPAA regulations regarding confidentiality. The conditions of e-mail communication are as follows:

- A signed consent by our patients is required.
- It is not to be used for urgent or emergency purposes
- All e-mail communications will become part of the patients permanent health record.
- Patients are recommended to not use work e-mails but it is their choice
- We expect to respond to e-mails within 24 hours

E-mail can be used for requesting referrals, prescription refills, to request appointments and results of tests through our website. www.heightsmedical.com

E-Mail Address: _____

Patient Printed Name: _____

Patient Signature: _____ Date: _____

Effective as of
December 1, 2014

Financial Policy

Due to changes in healthcare, please review the updated policy of Heights Medical

Thank you for choosing Heights Medical Associates. We are committed to providing you quality and affordable health care, and look forward to a lasting physician-patient relationship. As part of this relationship, we wish to establish joint expectations of your financial responsibility as outlined in this Financial Policy. Please review, ask any questions, and sign the following financial policy. A copy will be provided upon request.

1. ***Insurance.*** We accept assignment and participate in Medicare. We participate in most plans but not all. If you are not insured by an insurance carrier we participate 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; however, we will help you to the fullest extent of our ability. Your insurance company is the final arbiter of your coverage.

2. ***Co-payments and deductibles.*** All co-payments and deductibles must be paid prior to the time of service. There are NO exceptions. This arrangement is part of your contract with your insurance company. We accept cash, American Express, Discover, Visa, MasterCard and in-state checks.

3. ***Non-covered services***. Please be aware that some - and perhaps all - of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit. A fee schedule is available for your review.

4. ***Proof of insurance***. For privacy protection, all patients must complete our patient information forms with documentation with a copy of driver's license and proof of insurance prior to seeing the provider. 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. Most insurance companies have time filing restrictions; if a claim is not received within 30 days of the date of service, it can be rendered ineligible for payment and you will be responsible for the balance that remains.

5. ***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.

6. ***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.

7. ***Credit and Collection.*** If your account is over 90 days past due, you will receive a letter stating that you have 10 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 all necessary efforts for collection will be pursued. If a decision is made to discharge you from the practice, you will be notified by certified mail that you have 30 days to find an alternative practice for medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. ***Prompt Payment:*** Just as we will make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety; please contact our billing office to discuss payment options.

9. ***Form Completion:*** There will be a fee for any form completion other than state disability. There is an enormous cost to the practice in filling out forms such as FMLA, sick leave, AFLAC, and disability forms among others. The fee will range from $10.00 - $30.00 depending on the complexity of the form and must be paid in advance.

10. ***Missed Appointments***. We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of twenty-four (24) hours in advance if you are unable to do so. When we receive advanced notice of cancellation, we are able to avoid lost revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are unable to accommodate other patients needing care.

11. ***Uninsured Patients***. Please see our separate policy.

Our practice is committed to providing the best medical care to our patients.

Thank you for reading and understanding our financial and payment policy. After signing, please request a copy for your records.

Your signature reflects that you have read and understand the policy.

_____
Name (please Print)

_____
Signature

Date:_____