MEDICAL ART CENTER | PATIENT REGISTRATION

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Name	Last		First		MI
Street					
City		State		Zip	
Home Phone		Email			
Cell Phone		Birthdate	/ /	Age	
Gender	☐ Male ☐ Female	Employer			
Race		Work Phone			
Soc Sec #		☐ Full Time	☐ Part Time	☐ Retired	
Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Pharmacy				Phone	
Emergency Contact				Phone	

Referred By: Check All That Apply	☐ Friend	☐ Family	☐ Patient	
	☐ Facebook	☐ Doctor		☐ Healthgrades
	☐ Billboard	☐ TV	☐ Work	☐ Instagram

PRIMARY INSURANCE INFORMATION **For claim processing, please provide your insurance card(s) to the receptionist*

Insurance Company				
Insured Individual Last		First		MI
Address (if different)				
Birthdate		Soc Sec#		
Relation to Patient	☐ Self	☐ Spouse	☐ Child	☐ Other
Employer		☐ Full Time	☐ Part Time	☐ Retired
		Work Phone		

SECONDARY INSURANCE INFORMATION

Insurance Company				
Insured Individual Last		First		MI
Address (if different)				
Birthdate		Soc Sec#		
Relation to Patient	☐ Self	☐ Spouse	☐ Child	☐ Other

I hereby assign the policy rights and benefits to the Doctor, and authorize direct payment for professional services rendered. I further authorize the attending Doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance, deductible or co-payment to the Doctor; and if I perceive any payments from my insurance company in error, I will sign them directly over to the Doctor.

_____

Signature of Patient, Parent, Guardian or Personal Representative

_____

DATE

Name		Date	/ /
Patient Concerns			
Date of Last Physical			

CONFIDENTIAL FAMILY MEDICAL HISTORY

	Alive	Age of Death	Present Health or Cause of Death		Alive	Age of Death	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
			Age of Living Children				

CHECK (✓) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY

__Diabetes	__Cancer	__Bleeding Tendency	__Kidney Disease	__Tuberculosis
__Heart Disease	__Stroke	__High Blood Pressure	__Depression	__Allergies

MEDICATIONS and dosage you are currently taking, INCLUDE vitamins, herbs, supplements, etc.

CHECK (✓) IF YOU ARE ALLERGIC TO

__Adhesive Tape	__Ibuprofen	__Latex	__Aspirin
__Iodine	__Penicillin	__Local Anesthesia	__Sulfa

List any Allergies to medications or substances:

Do you take oral contraceptives? __No __Yes	Please list any of the following:

CHRONIC CONDITIONS	ACCIDENTS	DIAGNOSTIC TESTS
INJURIES/ILLNESSES	HOSPITILIZATIONS	SURGERIES

OTHER HEALTH CARE PROVIDERS

Primary Care	OB/GYN
Preferred Pharmacy	

Name **Location** **Number**

Living Will | Advance Directive? __No __Yes	May we have a copy for your chart? __No __Yes

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child every have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative **DATE**

Please PRINT name of Patient, Parent, Guardian or Personal Representative

HIPAA Notice of Privacy Practices

Medical Art Center | 950 State Route 35|Middletown NJ 07748|732-888-0017

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 is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, 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 condition and related health care services.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

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 Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory [*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease - Helping with product recalls - Reporting adverse reactions to medications - Reporting suspected abuse, neglect, or domestic violence - Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

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. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of Patient or Representative **Date**

PATIENT CONFIDENTIALITY (HIPAA)					
Name			**Date of Birth**		
Patient confidentiality is one of our priorities and it is the law (HIPPAA) implemented in 2003. Your privacy is a great concern in our office. Please indicate below with whom and where we may leave a message. When possible we try to confirm appointment as well as leave messages regarding medication, test results, and billing information.					
OUR OFFICE MAY LEAVE A MESSAGE AT					
HOME |Yes| No		**CELL |Yes| No**		**WORK |Yes| No**	

Due to our confidentiality requirements, should a family member, friend, or relative contact our office, please state who we have permission to discuss your condition/results with		
Name		**Relation**
Name		**Relation**
Name		**Relation**
Name		**Relation**
Please provide your email address to receive office information?		
Please be advised that it is you responsibility to inform us if any changes should be made to the above information. Thank you.		