# Rheumatology Center of Princeton

123 Franklin Corner Rd. Suite 106, Lawrenceville NJ 08648, Phone Number: 609-896-2505

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## Patient Information

| **Patient** | | | | | | |
|---|---|---|---|---|---|---|
| Name (Last, First, M.) | | Cell phone # | Age | Birthdate | Sex | Home or Other Phone # |
| Mailing Address | | City | State | Zip Code | Email address | |
| Nickname | Race (Optional) | Ethnicity (Optional) | | Marital Status | Language | |

| **Responsible Party** | | | | | |
|---|---|---|---|---|---|
| Name (Last, First, M.) | Relation to Patient | Age | Birthdate | Sex | Preferred Phone Number |
| Mailing Address | City | State | Zip Code | Email Address | |

| **Primary Provider** | Fax # if not local | **Referring Provider** | Specialty | Phone Number | Fax # |
|---|---|---|---|---|---|
| | | | | | |

| **Insurance Information** | | | | |
|---|---|---|---|---|
| Primary Insurance Company | Subscriber's Name, Birthdate | Relationship | Policy Number/Group # | Copay |
| Second Insurance Company | Subscriber's Name, Birthdate | Relationship | Policy Number/Group # | Copay |
| Third Insurance Company | Subscriber's Name, Birthdate | Relationship | Policy Number/Group # | Copay |

| **Pharmacy Information** | | | | | |
|---|---|---|---|---|---|
| Local Pharmacy | Address | Mark if Preferred | Specialty Pharmacy | Address | Marl if Preferred |

Signature: ____________________________________________________________ Date:_________________

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# FINANCIAL AGREEMENT

**INSURANCE COVERAGE**

It is the responsibility of the patient to keep the office up to date with any changes to their insurance coverage. If the patient fails to do so and the charges are denied by the insurance plan, then the charges will immediately become the sole responsibility of the patient. Occasionally your insurance plan may request coordination of benefit ("COB") information from you. Please do not ignore these inquiries as it will delay claim payment indefinitely. If the patient fails to respond to the COB request the resulting balance will become the sole responsibility of the patient and immediately due. Please refer to our website www.princetonrheumatology.com for the current list of participating insurance plans.

**PLANS REQUIRING REFERRALS**

All patients who have a managed care plan that requires an insurance referral must have an insurance referral for Rheumatology Center of Princeton or the individual physician to receive treatment. Generic referrals to "Rheumatology" will not be accepted. Failure to have the proper referral will result in being asked to reschedule your appointment or to become private pay for the visit. It is your responsibility to obtain a referral if your plan requires referrals to receive maximum benefits; the identification and maximization of patient benefit of these plans is not the responsibility of the practice. The practice will hold the patient responsible for any amounts categorized as patient responsibility by your insurance carrier.

**FINANCIAL RESPONSIBILITY**

The practice accepts patients who are both private pay and insured, it is the responsibility of the patient to determine the participation and benefit level of practice as it relates to the active insurance coverage. Co-pays, co-insurance, and deductibles are due and collected at time of service. If you do not have your copay at the time of your visit, you will be asked to reschedule your appointment. Valid forms of payment are Visa, Mastercard, Discover, Check, Cash or Money Order. The undersigned individual guarantees prompt payment of all charges.

**DELINQUENT ACCOUNTS**

The undersigned guarantees prompt payment of all charges. Delinquent accounts over 90 days will be forwarded to a collections agency and result in the discharge of the patient from the practice. Balances remitted to a Collection Agency will be charged a 30% administration fee as well as all costs and expenses including attorney fees.

**ASSIGNMENT OF BENEFITS**

The undersigned authorizes the release of any medical information necessary to process the patient's insurance claim(s); and authorizes/requests payment of medical benefits directly to the physician. This assignment covers all medical services rendered until such authorization is revoked in writing. If services are not covered by insurance or is private pay the undersigned is fully responsible for payment in full at the time of service.

**CERTIFICATION**

I understand and certified that I have read and fully accept the terms specified above. This agreement modifies any previous financial agreement versions; the original effective date remains the same. A photocopy of this form may be used in place of the original

____________________________________ ______________________________

Signature of Insured/Responsible Party Date

____________________________________ ______________________________

Printed Name Relationship if Guardian

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# Patient Consent for Use and Disclosure of PHI and NPP Receipt

The Patient hereby consents to the use or disclosure of personally identifiable information (also referred to as protected health information or PHI) and patient medical record / billing information by *Rheumatology Center of Princeton* in order to carry out treatment, payment and healthcare operations. The Patient should review our Notice of Privacy Practices (NPP) for a more complete description of the potential uses and disclosures of such information, the Patient has a right to review this document prior to signing this consent.

This Organization has the right to change the Notice of Privacy Practices at any time. If the terms of the Notice of Privacy Practices are changed the Patient has a right to obtain a copy of the revised Notice.

Patient acknowledges and agrees that this Organization may disclose the Patient's protected health information and/or medical record - billing information to the following individual(s) who are the Patient's family members, guardians, legal representatives, healthcare surrogates or have power of attorney on behalf of the patient. Indicate name, relationship, DOB, and contact information of the individual(s):

Name/DOB:___________________________________ Rel: ___________________ PH:___________________

Name/DOB:___________________________________ Rel: ___________________ PH:___________________

Name/DOB:___________________________________ Rel: ___________________ PH:___________________

The Patient agrees that this Organization may disclose the following types of information if contained in the Patient's medical - billing records (please initial the appropriate categories):

[______] HIV / AIDS Information [______] Sexually Transmitted Disease Information

[______] Mental Health Information [______] Substance Abuse Information

This Organization will utilize the patients address and telephone numbers for communications as provided on the demographics form unless an alternate form of communications is indicated.

At all times the patient has the right to revoke this Consent by submitting the revocation in writing. The revocation shall be effective *except* to the extent that this Organization has already taken action in reliance upon this Consent.

This Organization may refuse to treat the Patient if he/she (or authorized representative) does not sign this Consent form. This Organization has the right to refuse further treatment after the time this Consent is revoked (except to the extent this Organization is required to provide treatment under the law).

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This Organization has published a HIPAA 'Notice of Privacy Practices' (NPP). I have been informed and provided a copy of the NPP. A copy is also provided on our website at www.princetonrheumatology.com Please check one item below:

______ NPP paper copy provided

______ NPP will be reviewed on the website

______ NPP Declined

**I HAVE READ AND UNDERSTAND THE INFORMATION IN THIS CONSENT. I HAVE RECEVIED A COPY OF THIS CONSENT, AND AM THE PATIENT OR AUTHORIZED TO ACT ON THEIR BEHALF TO SIGN THIS SEALED DOCUMENTVERIFYING CONSENT TO THE ABOVE STATED TERMS.**

_____________________________________

**Print Name**

______________________________________________________ ______________________

**Patient or Legally Authorized Representative** **Date**

_____________________________________________________ ______________________

**Relationship to Patient If Signed by Another Party** **Date**

Please explain Patient's Representative Relationship to the patient and include a description of the Representatives authority to act on behalf of the patient.

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