North Jersey Endocrine Consultants, LLC
Cheryl R. Rosenfeld, DO, FACE, FACP
Shari N. Mintz, MD, FACE
Swati Sharma, MD
1Indian Road
Suite 8
Denville, NJ 07834

Telephone 973-625-2121
Fax 973-625-8270

PATIENT INFORMATION FORM
PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Last Name_____First Name_____
SS#_____Age_____Date of Birth_____
Address_____
City_____State_____Zip Code_____
Home Phone_____Work_____Cell_____
Email address_____
Employer Name_____Occupation_____
Employer Address_____

Spouse Last Name_____First Name_____
Date of Birth_____Work Phone_____

Emergency Contact_____
Relationship_____Phone_____

Who is financially responsible for this bill?_____

INSURANCE INFORMATION
Primary Insurance Name_____Phone_____
Name of Subscriber_____Date of Birth_____Relationship_____
ID#_____Group#_____

Secondary Insurance Name_____Phone_____
Name of Subscriber_____Date of Birth_____Relationship_____
ID#_____Group#_____

Referring or Primary Physician_____Phone_____
Address_____
Pharmacy Name and Phone #_____
Allergies_____

Assignment of Insurance Benefits

I authorize payment of medical benefits to North Jersey Endocrine Consultants, LLC for service rendered. I understand that I am financially responsible for any balance not covered by insurance. I authorize the release of medical information that may be necessary for either medical care or in application for financial benefit.

Patient Name (Print)_____
Signature_____Date_____
Parent/Guardian (for minor patients) _____

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PRIVACY CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient, we want you to know that we respect the privacy of your personal medical and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent on this document, at some future time you may request to refuse all or part of your PHI. Your may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgment

I,_____, have reviewed a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____ Date _____
Signature

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PATIENT CONFIDENTIALITY

In this office, Patient Confidentiality is a prime concern. Please indicate below with whom our office can or cannot leave a message. Please check where appropriate.

	YES	NO	DOESN'T APPLY
Spouse			
Children			
Home answering machine			
Work			

Are you able to receive calls at your workplace? _____
May we call you at your workplace and state who is calling? _____

Due to our confidentiality regulations, should a family member, friend, or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient.

Please check with whom we may discuss your situation.

	YES	NO	DOESN'T APPLY
Spouse			
Children			

Children and/or Significant Others

Name _____
Relationship _____
Phone _____

Name _____
Relationship _____
Phone _____

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we ask you to read and sign. Please be aware that prompt payment of your bill will enable us to maintain an efficient office committed to your care and well being.

All patients must complete our information and insurance form before seeing the doctor.

FULL PAYMENT IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECKS OR VISA/MASTERCARD (over $15)

Regarding Indemnity Insurance

We cannot bill your insurance company unless you give us your correct insurance information. Your insurance policy is a contract between you and your insurance policy. We are not a party to that contract. **If your insurance company has not paid your account in full within 45 days, the balance will be automatically transferred to you.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans in which we participate as a provider

All co-pays and deductibles are due at time of service. In the event that your insurance coverage changes to a plan that we do not participate with, refer to above paragraph.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. **You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary fees.**

Minor Patients

Adults accompanying a minor (parent or guardian) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, Visa and MasterCard, or payment by cash or check at time of service has been verified.

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Missed appointments

Unless cancelled, at least 24 hours in advance, our policy is to charge a fee of $50 for missed appointments. Established patients missing 3 or more appointments without cancelling in advance will be discharged from the practice. Please help us to serve you better by keeping scheduled appointments.

Other Fees

There will be a $10 charge for any medical forms that need to be filled out by the doctors. If you require a copy of your records, there will be a copy fee.

Insufficient Funds

A $25.00 fee will be charged for checks considered insufficient/cancelled funds. If continuous insufficiencies exist within your account, you will be required to pay by cash or credit card only.

Interest

We reserve the right to charge a monthly interest fee in the amount of 0.5% of your outstanding balance as provided by state law.

Collection Charges

In the event your account is turned over for collection, you agree to pay reasonable collection charges of 25% of the amount due and all court costs. Appointments may not be scheduled while your account is in collection.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ Date _____
Signature of Patient or Responsible Party

_____ Date _____
Signature of Co-Responsible Party