UROLOGIC HEALTH CENTER OF NEW JERSEY, P. C.
67 Route 37 West • Riverwood Plaza 11 • Suite 1• Toms River, NJ 08755 • Tel 732-914-1300 • Fax 732-914-0849

JOHN L. STONEHAM III, MD • PETER C. HOWARD, MD • VICTOR J. FERLISE, MD • ANDREW SALIB, MD

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

WELCOME TO UROLOGIC HEALTH CENTER OF NEW JERSEY!

TO BETTER SERVE OUR PATIENTS, WE WOULD LIKE TO INFORM YOU OF THE FOLLOWING POLICIES. PLEASE FEEL FREE TO SPEAK TO ANY MEMBER OF OUR STAFF IF YOU HAVE ANY QUESTIONS

- *Office Telephones* - Our office telephones will be answered by our staff Monday thru Friday from 8:15 am to 4:00 pm. The main phone number is **732-914-1300.** Fax # is **732-914-0849.**

- *Appointments* - Office hours are by appointment only. We will attempt to remind our patients of their appointment by phone 1-2 days prior. If you are unable to keep your appointment, kindly give us 24 hours notice.

- *Laboratory work and testing* - Prescriptions for blood work and other tests (ultrasound, x-rays etc) are given at the time of your visit. We do not mail prescriptions or test results, you would be required to pick up whatever you need at the main office. If you did not have your tests done before your follow-up appointment then that appointment will be re-scheduled. If another physician performed testing pertaining to your visit you are responsible for obtaining the results for your appointment.

- *Follow-up Appointments* - All test results will be discussed at the time of your visit.

- *Prescriptions* - If a prescription is needed please request it at the time of your office visit if possible. If a refill is needed between office visits a ***72 hour notice is mandatory.*** When leaving a request for a prescription refill, please be sure to give all required information (name with spelling, telephone #, date of birth and the name of the medication to be refilled). ***NO*** prescriptions will be filled on the weekends when the doctor does not have access to patients' charts.

- *Mail order prescriptions* - This office does not call in prescriptions to mail order companies.

- ***Referrals*** - Please be aware that it is the ***responsibility of the patient*** to know whether or not you need a referral with your insurance. If you do not have your referral at the time of your visit we will have to re-schedule your appointment. As a courtesy, we do try to remind the patient when a new referral is needed but again, it is the patient's responsibility to inquire.

- *Record Release* - One copy of test results will gladly be given at the time of your visit when requested. All other requests must be in writing, signed by the patient. No records will be faxed. **Please allow 10 business days to get your records prepared for you.**

- *Billing* - Please feel free to contact our billing office any weekday with any questions at 732-914-1300 ext 202 or 208.

I have received the Notice of privacy Practices and I have been provided an opportunity to review it.

Name _____ Birth Date _____

PLEASE SIGN HERE Signature **X** _____ Date _____

3. ENDING THIS AUTHORIZATION

Select one of the following two choices:

☐ This authorization will end on the following date: _____

☐ This authorization will end when the following event happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below.

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purposes may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign an authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. POSSIBILITY FOR REDISCLOSURE

I understand that information disclosed under this authorization may be re-disclosed by the recipient. Federal privacy rules may not protect the privacy of my health information once the recipient re-discloses my health information.

7. INDIVIDUAL PATIENT'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that, by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

PLEASE SIGN HERE

Signature **X** _____ Date: _____

If this authorization form is signed by a personal representative for the individual patient:

Personal Representative's Name: _____

Print name

_____

Signature

Representative to Individual Patient: _____

YOU HAVE THE RIGHT TO HAVE A COPY OF THIS FORM AFTER YOU SIGN IT.

Submit the authorization to the Privacy Office and include a copy in the individual patient's medical record.

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INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE.

PSYCHOTHERAPY NOTES: _____ Check here if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, it may not authorize the use or disclosure of any other type of protected health information.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in Section 2 below.
I give this authorization voluntarily

Your Name _____

Your Street Address _____

Your City _____ State _____ Zip _____

Your Telephone Number _____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Describe in detail the protected health information you are authorizing to be used and/or disclosed (if this authorization is for psychotherapy notes, no other type of protected health information may be listed here).

_____

_____

Name the people and/or organizations (or the kinds of people and/or organizations) that you are authorizing to use and/or to disclose the protected health information described above.

_____

Name the people and/or organizations (or kinds of people and/or organizations) that you are authorizing to receive and use your protected health information.

Dr. _____

Describe each purpose for which you are authorizing your protected health information to be used and/or disclosed.

Family: _____

_____

UROLOGIC HEALTH CENTER OF NEW JERSEY

PATIENT'S CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Urologic Health Center at New Jersey to use and disclose protected health information (PHI) about me to carry out treatment payment and healthcare operations (TPO). (Urologic Health Center of New Jersey's Notice of Privacy Practices provides 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. Urologic Health Center of New Jersey reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Urologic Health Center of New Jersey, Privacy Officer at 67 Route 37 West, Riverwood Plaza II, Toms River, NJ 08755.

With this consent, Urologic Health Center of New Jersey may call my home or other alternative 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 rerminders, insurance items and any calls pertaining to my clinical care including laboratory results among others.

With this consent, Urologic Health Center of New Jersey may mail to my home or other alternative location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, Urologic Health Center of New Jersey may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements I have the right to request the Urologic Health Center of New Jersey restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Urologic Health Center of New Jersey's use and disclosure of my PHI to carry out TPO.

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, or later revoke it, Urologic Health Center of New Jersey may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____

Print Name of Patient or Legal Guardian

_____

Date

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FINANCIAL POLICY

This policy applies to all patients. Payment is due at the time service is received. For your convenience, we accept cash, check or money order. Co-payments must be paid on the date of service. Patients are responsible for deductibles, coinsurance amounts and charges not paid by insurance due to failure to present proper paperwork. All changes are subject to a chart and coding review prior to being finalized. Bills on demand are estimates only and should not be used for claims nor are considered final bills.

As a courtesy, our office will automatically file primary and secondary insurance claims. Patients' balances due are billed monthly. Accurate and complete insurance information, including changes must be provided to registration at time of service. We will directly bill patients who fail to provide correct, timely information. We understand that unusual circumstances may arise and that payment in full at the time of service or post insurance payment may not always be possible. Payment plans are available, however, patients must discuss special payment needs with our Practice Administrator for prior approval.

Accounts not paid in accordance to our terms of credit or incomplete financial arrangements will nullify any prior agreements. Physician services are provided to patients, not insurance companies, thus patients are responsible for charges for care received. If your insurance has delayed payment on clean claims past 180 days, balances will revert back to direct patient's responsibility. Patients can then independently deal with their insurance. Patient's balances due are payable within 30 days after the date of first invoice. A late fee of 1.5% monthly interest will be charged to delinquent accounts, commencing on the thirtieth (30) day after first date billed. We may at any time after 90 days turn any delinquent account over to collections. Balances in collection are payable to our agent, Berk's Collection and will include the agent's fee in addition to our charges. Agency fees are typically 40-50% of the balance due.

Other fees: Returned check fee is $25.00 per occurrence. A $2.00 per form fee, plus any postage applies to forms over and above normal billing and/or medical records handling. Examples of such forms are rental assistance forms or disability forms other than from the State or Federal government. A $100 per page plus postage applies to medical records requested or subpoenaed by attorneys or other types of insurance companies, i.e. life, disability.

In cases of divorce, the parent who brings the child/children in for treatment is responsible for payment and for collecting from the other parent or attorney.

This office does not accept letters of protection, nor do we bill third parties such as business or homeowner policies. We do not and will not become an additional party in such matters. We expect payment the day services are provided and will not extend credit based on agreements patients have established with some other party. Patients must therefore obtain reimbursement themselves.

Urologic Health Center is a participating Medicare provider and supplier. Standards are posted in our office and available by mail upon request. This office will not comply with requests by patients that are considered fraud by the US Government and/or NJ. If you have questions on your bill or believe it to be in error, please notify our billing department immediately. Representatives receive ongoing training and are available to answer your questions. Our Compliance Officer is also available should you require additional assistance. Medicare and commercial insurance policies are complex and contain many details. We will gladly assist you with any questions you have, however, if you are ultimately dissatisfied with our billing, you may call your insurance company and we will be glad to work directly with them to resolve any issues. Please call our office if you have any further questions. Thank you.

I hereby certify that I have read Urologic Health of NJ, PC's financial policy and understand my financial responsibility and agree to the terms stated in the Financial Policy.

PATIENT'S SIGNATURE _____ DATE _____

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*Patient's Name:*_____ *DOB:*_____

Medical Conditions:

___AIDS/HIV	___ANEMIA	___VARICOSE VEINS	___HEART ATTACK	___A FIBRILLATION
___ARTHRITIS	___THYROID	___SINUS	___MITRAL VALVE PROLAPSE	___CARDIAC STENTS
___EPILEPSY	___HEMORRHOIDS	___ULCER	___ANGINA	___HIP REPLACEMENT
___HEPATITIS	___CANCER	___BLOOD PRESSURE	___HEART MURMUR	___KNEE REPLACEMENT
___ASTHMA	___LIVER DISEASE	___HERNIA	___GLAUCOMA	___PACEMAKER
___PNEUMONIA	___DIABETES	___SEVERE INDIGESTION	___CHOLESTEROL	___KIDNEY DISEASE
___RECTAL BLEEDING		___REFLUX	___PSYCHIATRIC CARE	

Surgery:

Date: _____

Procedure: _____

Hospital: _____

Allergies: _____

Medications: _____

_____

_____

Family History: ____ Heart Disease ____ Prostate Cancer
____ Kidney Stones Cancer _____

Social History: ____ *Smoker/How Long?* ____ *Packs per day* ____ *Alcohol Drinks* ____ *per day/week(circle one)*

Review of Systems: ____ *12 System negative other than HPI and* _____

*Pharmacy:*_____ *Phone:*_____

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*LAST NAME:*_____ *FIRST NAME:*_____ *MI:*____

*SOCIAL SECURITY #:*_____ *DATE OF BIRTH:*_____

*HOME ADDRESS:*_____

*CITY:*_____ *STATE:*_____ *ZIP:*_____

*PATIENT'S SEX:*____ *MALE* ____*FEMALE* *MARITAL STATUS:* ___*SINGLE* ___*MARRIED* ___*DIVORCE* ___*WIDOW*

*HOME PHONE:*_____ *WORK PHONE:*_____

*CELL PHONE:*_____

*REFERRING PHYSICIAN:*_____ *PRIMARY CARE PHYSICIAN:*_____

PRIMARY INSURANCE CO.:_____ *ID#:*_____

*INSURANCE CO ADDRESS:*_____ *GROUP #:*_____

*INS CO PHONE #:*_____ *GUARANTOR'S RELATIONSHIP:* ___*SELF* ___*SPOUSE* ___*CHILD* ___*OTHER*

*GUARANTOR'S NAME:*_____ *DOB:*_____ *SOC. SEC. #:*_____

SECONDARY INSURANCE CO.:_____ *ID#:*_____

*SEC INS CO ADDRESS:*_____ *GROUP#:*_____

*SEC INS CO PHONE#:*_____ *GUARANTOR'S RELATIONSHIP:* ___*SELF* ___*SPOUSE* ___*CHILD* ___*OTHER*

*GUARANTOR'S NAME:*_____ *DOB:*_____ *SOC. SEC. #:*_____

EMPLOYER'S NAME: _____ *PHONE:*_____

*ADDRESS*_____

*EMERGENCY CONTACT (not living with you):*_____ *RELATIONSHIP:*_____

*Telephone #:*_____

*REASON FOR INITIAL VISIT:*_____

*HOW DID YOU HEAR ABOUT OUR OFFICE:*_____