

**ACKNOWLEDGEMENT OF RECEIPT OF THE
NOTICE OF PRIVACY PRACTICES
OF
Plaza Family Care**

Patient Name: _____ Date _____ of
Birth: _____

Address: _____ Telephone _____
No: _____

I hereby acknowledge that I have received from Plaza Family Care a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices sets forth my rights relating to the use and disclosure of my personal health information and explains how Plaza Family Care may use and/or disclose my personal health information both with and without my authorization. I further understand that I may contact the Privacy Officer if I have any questions regarding the contents of this Notice of Privacy Practices or to file a complaint about the privacy practices of Plaza Family Care.

Signature of Patient or Patient's
Representative

_____ Date

HIPAA NOTICE OF PRIVACY PRACTICES

Plaza Family Care, PC
657 Willow Grove Street
West Wing – Suite 401
Hackettstown, NJ 07840
908.850.7800

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 describes how we 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 and future physical or mental health or condition and related health care services.

1. Uses and Disclosers of Protected Health Information

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, Public Health Issues as required by law, Communicable Diseases: Health Oversight, Abuse or Neglect: Food & Drug Administration requirements: Legal Proceedings, Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to restrictions that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

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 privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

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. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. (908.850.7800)

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: _____ Signature: _____ Date: _____



FAMILY CARE, PC

Children's Center • Adult Medical Center

PEDIATRICS/INTERNAL MEDICINE

West Wing Medical Plaza • (Behind HRMC)

657 Willow Grove Street - Suite 401

Hackettstown, NJ 07840

245 Main Street

Suite 300/302

Williamson Building

Chester, NJ 07930

908.850.7800

FINANCIAL POLICY

We are committed to providing the best possible care to our patients and their families, and feel this goal is best achieved if everyone is aware of our office policies. Your clear understanding of our financial policy is important to our professional relationship.

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. Full payment is expected at the time of service. This especially includes applicable deductible and co-payments for participating insurance companies. Plaza Family Care, PC., accepts cash, personal checks, Visa, Master Card and American Express. You will be given an itemized statement every time you or your child is seen in the office.

The benefit packages provided by insurance companies vary from employer to employer. Medical insurance is a contract between you, your employer and your insurance company. Not all services are a covered benefit in all contracts. You need to learn the benefits in your policy (including vaccine and well-child coverage) and follow the rules of the policy (such as authorization for specialty care, procedures, lab tests and emergency room use). We will bill the insurance companies we participate with, but if we are not paid in a timely fashion, you will be expected to pay the bill in full. Except as provided by such contract or by State law, we will hold you responsible for all charges. Any services rendered to you or your children that are not a covered benefit according to your insurance will be billed to you.

If you are experiencing financial difficulty, please let us know. In no case will a patient present to our office, with an urgent problem, be turned away because of financial problems.

If you need assistance or have any questions, our billing staff can be reached at (908) 850-7800 between the hours of 8:30 a.m. and 4:30 p.m. Monday through Friday.

Every minor child, under age 18, seen in our offices for medical services must be accompanied by a parent or legal guardian, or by an adult who has obtained written consent for treatment from the parent or legal guardian. An exception is an adolescent presenting for confidential services, which we are permitted by State law to provide without notifying the parent.

The accompanying parent or other adult is responsible for full payment at the time of service and must have the proper insurance card. In the case (such as divorce), where the custodial parent is not the insurance holder, we will bill the covering insurance company or non-custodial parent. If there should be a dispute about the financial responsibility, we will then hold the accompanying adult responsible for payment. It will then be up to him/her to seek repayment from the other parent. We find it very difficult to look after your child's medical care when we are placed in the middle of a marital dispute.

If your insurance plan requires us to complete a referral in order for you or your child to see a specialist, or for procedures or lab tests, you must allow three (3) business days to complete the appropriate forms prior to obtaining services. Retroactive referrals cannot be processed and will not be honored. In general, we will not agree to a referral for a problem we have not been consulted with first.

Our referral department (908) 850-7800, can be of great assistance in answering your questions, but please do not ask them to violate insurance contracts or our office policies.

Broken appointments are a cost to us, to you, and to other patients who could have used the time set aside for your appointment. Please call us at least 24 hours in advance to make any scheduling changes you need. We reserve the right to charge a \$25.00 fee to your account if we find that you continue to miss appointments without advance notice. Excessive abuse may result in dismissal from the practice. There is a fixed \$125.00 fee for missed Neurodevelopmental appointments.

As stated above, all fees are due at the time of service. Any charges remaining unpaid sixty (60) days after the date of service are considered past due. In this case, we will make every effort to contact the person responsible for the delinquent balance, and arrange an equitable payment schedule. However, if no effort is made to pay the balance due, it may be sent to a collection agency. In this case the responsible person will be asked to seek medical care for themselves and their families elsewhere.

- I have read and understand the Plaza Family Care, PC financial policy.*
- I agree to keep Plaza Family Care, PC accurately informed of my insurance status for either myself and/or family members and to assign benefits to Plaza Family Care, PC.*

Signature of Insured or Authorized Representative

Date: _____

PATIENT INFORMATION

FIRST NAME _____ INITIAL _____ LAST NAME _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ WORK PHONE _____

DATE OF BIRTH _____ SOCIAL SEC. # _____

() SINGLE () MARRIED () WIDOWED () DIVORCED () SEPARATED

EMPLOYERS NAME _____ OCCUPATION _____

BUSINESS ADDRESS _____

BUSINESS PHONE _____

IN CASE OF AN EMERGENCY, WHO SHOULD BE NOTIFIED?

NAME _____ HOME PHONE _____

RELATIONSHIP _____ WORK PHONE _____

INSURANCE INFORMATION

PRIMARY INSURANCE _____

ID # OR POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

SECONDARY OR SUPPLEMENTAL INSURANCE _____

ID # OR POLICY # _____ GROUP # _____

SUBSCRIBER NAME _____ SUBSCRIBER DOB _____

PLEASE READ AND SIGN THE FOLLOWING

I hereby authorize Plaza Family Care, PC to furnish information to insurance carriers concerning my illness & treatments, and I hereby assign to the medical group all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

SIGNED: _____ DATE: _____

PLAZA FAMILY CARE, P.C.
INTERNAL MEDICINE

HEALTH HISTORY QUESTIONNAIRE

PATIENT NAME: _____ AGE: _____ GENDER: ___ F ___ M

PLEASE LIST ANY CHRONIC ILLNESS OR MEDICAL PROBLEM WHICH YOU MAY HAVE:

LIST THE MEDICATIONS WHICH YOU CURRENTLY TAKE: _____

WHO WAS YOUR PREVIOUS DOCTOR: _____

| HAVE YOU EVER HAD ANY OF THE FOLLOWING ILLNESSES: | | | WHAT TYPE / EXPLANATION |
|---|---------|--------|-------------------------|
| 1. HIGH BLOOD PRESSURE | YES ___ | NO ___ | _____ |
| 2. DIABETES | YES ___ | NO ___ | _____ |
| 3. ASTHMA | YES ___ | NO ___ | _____ |
| 4. THYROID DISEASE | YES ___ | NO ___ | _____ |
| 5. HIGH CHOLESTEROL | YES ___ | NO ___ | _____ |
| 6. HEART DISEASE / ATTACK | YES ___ | NO ___ | _____ |
| 7. ARTHRITIS | YES ___ | NO ___ | _____ |
| 8. ANEMIA | YES ___ | NO ___ | _____ |
| 9. CANCER | YES ___ | NO ___ | _____ |
| 10. BLEEDING DISORDER | YES ___ | NO ___ | _____ |
| 11. HEPATITIS | YES ___ | NO ___ | _____ |
| 12. KIDNEY DISEASE | YES ___ | NO ___ | _____ |
| 13. STROKE | YES ___ | NO ___ | _____ |
| 14. DEPRESSION | YES ___ | NO ___ | _____ |
| 15. LYME DISEASE | YES ___ | NO ___ | _____ |
| 16. PSYCHIATRIC ILLNESS | YES ___ | NO ___ | _____ |
| 17. SEIZURES | YES ___ | NO ___ | _____ |
| 18. ALCOHOLISM | YES ___ | NO ___ | _____ |
| 19. LUNG DISEASE | YES ___ | NO ___ | _____ |
| 20. IRRITABLE BOWEL | YES ___ | NO ___ | _____ |
| DO YOU SMOKE | YES ___ | NO ___ | _____ |

WHO REFERRED YOU TO OUR OFFICE: _____