

# Northern New Jersey Eye Institute P.A.

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Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_  
E-Mail Address \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Gender  Male  Female Marital Status  Single  Married  Widowed  Divorced  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employment Status  Full-Time  Part-Time  Retired  On Leave  Other  
In case of emergency contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Cell Phone ( ) \_\_\_\_\_

**REFERRING PHYSICIAN/ COMPLETE NAME AND ADDRESS:**

\_\_\_\_\_  
**PRIMARY CARE PHYSICIAN (PCP)** (if different from Referring Physician) **COMPLETE NAME AND ADDRESS:**

**INSURANCE INFORMATION** ~ We will need a copy of your insurance card(s).

Primary Insurance	Address (Street/City/State)	Employer
Group # _____ ID # _____	Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent/Guardian	
Secondary Insurance	Address (Street/City/State)	Employer

Group # \_\_\_\_\_ ID # \_\_\_\_\_ Policy Holder:  Self  Spouse  Parent/Guardian

Other Insurance	Address (Street/City/State)	Employer
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Group # \_\_\_\_\_ ID # \_\_\_\_\_ Policy Holder:  Self  Spouse  Parent/Guardian

**INSURED RESPONSIBLE PARTY INFORMATION** ~ If other than self

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_  
Address (if different from patient) \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Work Phone ( ) \_\_\_\_\_ Employer \_\_\_\_\_

## ACCIDENT INFORMATION

Is this a Work Comp or Motor Vehicle Accident? Yes No If YES, on what date did the injury occur? \_\_\_\_\_  
Work Comp/Motor Vehicle Claim Number \_\_\_\_\_  
Adjuster's Name \_\_\_\_\_  
Phone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_

I authorize that payment of any insurance benefits for health care services be made directly to Northern NJ Eye Institute P.A. NOTE: If patient is a minor under the age of 18 years, these forms must be signed by parent or legal guardian. They cannot be signed by a minor.

Signature of Patient, Parent or Legal Guardian

Date



# Northern NJ Eye Institute

Excellence In Eyecare<sup>SM</sup>

## Authorization for Use and Disclosure of Protected Health Information

### Patient Identification

Printed Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Telephone: \_\_\_\_\_

Northern N.J. Eye Institute is authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Northern N.J. Eye Institute to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization if done so in writing.

### *Please check type of information to be released:*

- Complete Health Record
- Complete Billing Record
- Lab Results
- X-Ray Reports

I, the undersigned, authorize and request the above referenced provider to release information to:                      Spouse                      Children                      Other

Name/Relationship: \_\_\_\_\_

NNJEI can leave medical information on my home answering machine? Yes \_\_\_\_\_ No \_\_\_\_\_  
Initial      Initial

### Drug and/or Alcohol Abuse, and/or Psychiatric, and/or HIV-AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment and/or other sensitive information, and I agree to its release as noted above.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorization to sign if not patient: \_\_\_\_\_  
(Name)                      (Relationship)



# Northern NJ Eye Institute

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## NOTICE OF PRIVACY PRACTICES

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**THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.**

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### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice has been revised as of September 1, 2005, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using information listed at the end of this Notice.

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved in Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security:** We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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#### **PATIENT RIGHTS**

**Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$\_\_\_\_ for each page, \$\_\_\_\_ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**Disclosure Accounting:** You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication:** You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice:** If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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#### **QUESTIONS AND COMPLAINTS**

If you want more information about our privacy practices or have questions or concerns, please contact us and ask to speak with our HIPPA Compliance Officer in person or by phone.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Northern New Jersey Eye Institute, P.A.**  
**Lifetime Signature Agreement**  
**(Must be completed prior to exam.)**

- I consent to treatment for this patient

I hereby authorize my insurer to assign and transfer any and all applicable plan or policy benefits and rights to Northern NJ Eye Institute and any appointed business associates working with them for the sole purpose of making sure all protected rights and benefits under my plan are administered accurately, including the right to all remedies, disclosures, rights of appeal, administrative reviews and litigation on my behalf. This authorization includes any and all other rights permissible under state and federal laws. I understand under all applicable state and/or federal regulatory guidelines that I, having the right and authority, designate payment to be made and mailed directly to the provider listed for all services rendered.

I authorize any holder of medical information and medical records about me to be released to the Healthcare Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

- I authorize the release of medical information for the purposes of treatment, payment or healthcare operations.
- I understand and agree to pay any or all co-payments and deductibles at time of service, or I may be responsible for a \$20.00 service charge.
- I understand that all fees and services are due payable at the time services are rendered if the Northern New Jersey Eye Institute does not participate in my insurance plan, unless written arrangements are made.
- I understand that I am responsible to bring any necessary referrals at the time of service, or I may be liable for all charges.

I understand that there may be a service charge of 1.5% per month for any unpaid balance more than thirty days past due. I also agree to pay all responsible attorney fees and collection costs in the event of default of payment of my charges.

- I authorize the transfer of all unpaid amounts to my Visa/Mastercard/American Express after 120 days from the date of service.
- I understand that if I am billed Medicare's reduced rate and it is determined that I am not Medicare eligible; I will be billed at the Institute's standard rate.
- I understand that I am responsible for any services that are not covered by my insurance company.
- Further, I understand that I am entering into a contractual relationship with the medical practice/physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may have result in irreparable harm to a medical provider. As additional consideration for my professional care provided to me by medical practice/physician, I (the patient) and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against medical practice/physician.
- Furthermore, should a meritorious medical malpractice care of cause of action be initiated or pursued, I (the patient) and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as (physician). Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case. In further consideration for this, I (the physician), agree to the same stipulations.
- I have read and fully understand the above consent for treatment, financial responsibility, release of medical information and insurance authorization.

\_\_\_\_\_  
Signature of Patient, Parent or Legal Guardian

\_\_\_\_\_  
Date