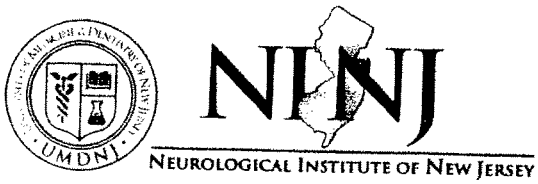

NEUROLOGICAL INSTITUTE OF NEW JERSEY
90 BERGEN STREET, 8TH FLOOR
NEWARK, NJ 07103

PATIENT INFORMATION

DATE_____ CELL PHONE # (___)_____

HOME PHONE # (___)_____

PATIENT_____
LAST FIRST

RESPONSIBLE PARTY *(if a minor)*_____
MOTHER'S NAME FATHER'S NAME

ADDRESS_____

_____
CITY STATE ZIP CODE

SEX: M ☐ F ☐ AGE_____BIRTHDATE_____RACE_____RELIGION_____

☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ SEPARATED ☐ DIVORCED ☐ PATIENT SS#_____

PATIENT EMPLOYED BY:*(If a minor, parents please provide your employment information)*

_____

BUSINESS ADDRESS_____

OCCUPATION_____YEARS EMPLOYED_____BUSINESS PHONE _(___)_____

SPOUSE'S NAME_____
LAST FIRST

EMPLOYED BY:_____

BUSINESS ADDRESS_____

OCCUPATION_____YEARS EMPLOYED_____BUSINESS PHONE _(___)_____

IN CASE OF EMERGENCY, CONTACT

NAME_____RELATIONSHIP TO YOU_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

HOME PHONE # _(___)_____ BUSINESS PHONE # _(___)_____

REFERRING AND PRIMARY CARE PHYSICIAN INFORMATION

REFERRING PHYSICIAN
LAST/FIRST NAME_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

TELEPHONE # _(___)_____ FAX # _(___)_____

PRIMARY CARE PHYSICIAN
LAST/FIRST NAME_____

ADDRESS_____CITY_____STATE_____ZIP CODE_____

TELEPHONE # _(___)_____ FAX # _(___)_____

INSURANCE INFORMATION

PRIMARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT?_____
LAST/FIRST NAME

RELATIONSHIP TO PATIENT_____ SS#_____ BIRTHDATE_____

INSURANCE COMPANY_____

MEMBERS ID #_____ GROUP #_____

INSURANCE CLAIMS ADDRESS_____

MEMBER CUSTOMER SERVICE #_____

SECONDARY INSURANCE

PERSON RESPONSIBLE FOR ACCOUNT?_____
LAST/FIRST NAME

RELATIONSHIP TO PATIENT_____ SS#_____ BIRTHDATE_____

INSURANCE COMPANY_____

MEMBERS ID #_____ GROUP #_____

INSURANCE CLAIMS ADDRESS_____

MEMBER CUSTOMER SERVICE #_____

ASSIGNMENT OF INSURANCE BENEFITS

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and / or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and / or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize _____
(Name of Insured) (Name of Insurance)
to pay and hereby assign directly to _____ all benefits, if any, otherwise
(Provider's Name)
payable to me for his/her services as described on the attached forms. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid to _____, will be credited to my account, in accordance with
(Provider's Name)
the above said assignment.

_____ _____
(Authorized Signature) (Date)

(OFFICE USE ONLY)

CPI#_____ **MED REC#**_____

ATTENDING_____

PATIENT RECORD OF DISCLOSURES

In general the Hippa Privacy rule gives individuals the right to request a restriction on uses and disclosures of their prote health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to individuals office instead of the individual's house.

I wish to be contacted in the following manner (please check all that apply):

☐ Home Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to mail to my home address
- ☐ O.K to mail to my work/office address
- ☐ O.K to fax to this number

☐ Work Telephone _____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Other _____

_____
Patient Signature

_____
Date

_____
Print Name

_____
Birthdate

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of and request for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosure made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosures information provided below. If completed properly, will constitute an adequate record.

Note: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address of Fax Number	(1.)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2.)	(3.)

1 Check this box if the disclosure is authorized
2. Write in box: T= Treatment records P= Payment Information
3. Enter how disclosure was made: F= Fax P=Phone E=Email M=Mail O=Other

NEW JERSEYMEDICAL SCHOOL

University OF Medical & Dentistry Of New Jersey

NEW JERSEY MEDICAL SCHOOL
ACKNOWLEDGEMENT OF RECEIPT
NOTICE OF PRIVACY PRACTICE

We keep record of the health care services we provide for you. You may ask to see and copy that record. You may also ask us to correct that record. We will not reveal your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contracting our office's Practice Administrator/Manager.
Our Notice of Privacy Practices describes more in detail, how your health information may be used and revealed, and how you can obtain your information.

* You May Refuse to Sign This Acknowledgement *

I,_____, have received a copy of this OfficeNotice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

_____

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____

_____

_____

Employee's Signature and Date _____