2016 RARITAN FAMILY HEALTH CARE

PATIENT DEMOGRAPHIC INFORMATION

Name: _____ Birth Date_____ Home Phone_____

Address: _____ City: _____ State: _____ Zip:_____

No. P.O. Box _____ Social Security ___-__-____ Cell Phone No. _____

Email Address: _____

Circle Appropriate Selection: Minor Single Married Divorced Separated Widowed DP/CU

Race (OPTIONAL): Asian African-American Hispanic Native American Caucasian Other

Language: _____

What is Your Preferred Method of Communication: E-Mail ____ Mobile____Home Phone____Text____

Is Patient Visually Impaired ? Yes No Physically Impaired ? Yes No Hearing Impaired ? Yes No

Person To Contact in Case of Emergency: _____ Phone Number: _____

IF STUDENT: Name of School/College: _____ City: _____ State: _____

Patient's/ Parent's Employer _____Work Phone No: _____

Business Address: _____ City: _____ State: _____ Zip: _____

Spouse / Parent's Name _____ Birth Date: _____

Employer: _____Address: _____ Work No: _____

RESPONSIBLE PARTY/INSURANCE INFORMATION

Name of Insured: _____ Relationship to Patient: _____

Birth Date: _____ Social Security No. ___-__-____ Date Employed:_____

Name of Employer: _____ Union/Local No.:_____ Work Phone No. _____

Address of Employer: _____ City: _____State: _____ Zip: _____

Insurance Company: _____ Group No. _____ Policy ID No._____

Insurance Address: _____ City _____State _____ Zip _____

Name of Person Responsible for this Account if other than Insured: _____

Relationship to Patient: _____ Social Security No. ___- __ - ____

Address: _____ City: _____ State:_____ Zip: _____

I hereby give my consent for Raritan Family Health Care to View my external prescription history through electronic history records. I also consent to any medical and/or surgical treatment deemed necessary during the course of my medical treatment with Raritan Family Health Care. While Raritan Family Health Care consciously makes every effort to call with all tests results within a 7 day period, I am aware that if I Have not heard from the office by at least 7 days I am to call to follow up on those tests that were performed at my office visit.

Print Name: _____ Signature: _____ Date: _____

RARITAN FAMILY HEALTH CARE

2016 FINANCIAL DECLARATION STATEMENT

All payments for doctor and nurse visits are due at the time of service unless previous arrangements have been made with the billing department at Raritan Family Health Care.

Co-pays and deductibles apply for all types of office visits including all nurse visits.

In an effort to provide patients with quality care, certain procedures may not be deemed necessary by the insurance companies, Medicare, Cigna, Blue Cross Blue Shield, Aetna, etc. I understand that although Raritan Family Health Care is submitting information to my insurance company on my behalf, I am ultimately responsible for charges incurred that may not be covered by my insurance.

Services which are allowed by insurance but result in patient responsibility (ex: deductible, coinsurance) will be applied to my balance and I will be responsible for payment. I am aware of possible after hours charges (5p.m or later) and weekend charges (Sat/Sun), which are allowable charges for most insurance companies. Should these charges be applied to my deductible or coinsurance, I will be responsible for payment.

In the event that this account is placed with an attorney or in a collection agency because of an unpaid balance remaining on my account, I hereby agree and promise to pay interest of 1.5% per month of the outstanding balance to be calculated starting from my last date of service. In addition, I also agree and promise to pay a collection fee of $50.00 or 20% of the total balance due, whichever is greater, upon placement with an attorney or collection agency because of an unpaid balance remaining on my account.

In the event that my account does go into collections, I understand that Raritan Family Health Care's policy is that I will not be able to make an appointment or renew any medications until my balance is paid in full. I also understand that it is the right of Raritan Family Health Care to discharge me from the practice.

Return check fee is $30.00.

I also understand should I miss a physical appointment without cancelling twenty-four (24) hours in advance a $60 fee will be charged.

I have read and understand the above financial declaration.

PRINT _____ DATE_____

SIGNATURE_____

HIPAA GENERAL CONSENT FORM

Patient Name: _____ Date of Birth: _____

THIS IS NOT AN EMERGENCY CONTACT FORM

Due to HIPAA requirements we are not allowed to give any information to anyone other than the patient without the patient's consent. Any patient who is 18 years old or older needs to give consent before information can be given to any other person. **THIS FORM WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT.**

Who would you like your patient information to be given to?

Only the Patient_____ Phone number to be called _____

A Spouse _____ Please write their name _____

Please write their phone # _____

A Parent _____ Please write their name _____

Please write their phone # _____

Other _____ Please write their name _____

Please write their phone # _____

Can a message be left on an answering machine? YES NO

_____ _____

SIGNATURE OF PATIENT DATE

RARITAN FAMILY HEALTH CARE
901 US Highway 202
Raritan, New Jersey 08869
Phone 908-253-6640
Fax 908-253-6908

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I _____ hereby authorize _____
Patient's Name Date of Birth Name of Medical Facility **(Leave Blank)**

to release any and all medical records to my primary care physician _____
Physician's Name **(Leave Blank)**

_____ _____
Patient's Signature and / or Guardian if Minor Date **(Leave Blank)**

RARITAN FAMILY HEALTH CARE

901 US Highway 202
Raritan, New Jersey 08869
(t) 908-253-6640 (f) 908-253-6908

2345 Lamington Road, Suite 104
Bedminster, New Jersey 07921
(t) 908-781-9800 (f) 908-781-9801

SIGNATURE FOR NOTICE OF PRIVACY POLICY

By signing this form, I attest that I have read and understand Raritan Health Family Care's Notice of Privacy Practices policy. Upon request, I am aware that I may receive a copy of this "Notice".

PATIENT'S NAME (PRINT) _____ DATE _____

PATIENT'S SIGNATURE _____ DATE OF BIRTH _____