Account # ______________

King of Prussia Medicine Registration Form

(Please Print)

Patient: ______________________, ______________________ _____ **Birth Date:** __________ **Age:** ____
(Last Name) (First Name) (Middle Initial)

Sex: *Male Female* **Marital Status:** *Single Married Widowed Separated Divorced Partnered*
(Please Circle) (Please Circle)

Social Security: ________- _____- _______ **Email:** ________________________

Race: ______________________ **Ethnicity:** *Latino Non-Latino* **Language:** _____________
(Please Circle)

Home Phone: _____________________________ **Cell Phone:** _____________________

Address: _________________________________ __________________ ______________ ____________
(City) (State) (Zip)

Pharmacy Name: _______________________ **Pharmacy Number:** ___________________

Emergency Contact: _____________________ **Relationship:** ________________ **Phone:** ________________

Occupation: ____________________ **Employer:** _______________________ **Work Phone:** _______________

Medical Insurance Company: __________________________________ **Policy Effective Date:** _____________

Policy #: _______________________________ **Group #:** ______________________________

Subscriber: __________________________________ **Subscriber DOB:** ____________________

Subscriber Address: _______________________________ **Social Security:** ____- _____- _____
(Required for Claim Submission if policy holder is not the patient)

Secondary/Supplemental Insurance Coverage: _____________________________ **Effective:** ___________

Policy #: ____________ **Group #:** ________ **Subscriber:** ______________________ **DOB Subscriber:** __________

Consent for Treatment and Authorization to Release Information:
I hereby authorize King of Prussia Medicine, through its appropriate personnel, to perform or have performed upon me, or the above patient, appropriate assessment and treatment procedures. I further authorize King of Prussia Medicine, to release to appropriate agencies, any information acquired in the course of the above patient's examination and treatment.

Patient/Guarantor Signature: ____________________________________ **Date:** ___________________

King of Prussia Medicine
860 First Ave. Suite 4B
King of Prussia, Pa 19406
(T) 610-265-1251 (F) 610-265-1252

Dr. Ann G. Till
Dr. Melissa R. Cognetti
Dr. Frederic Becker

Authorization for Release of Health Information

Patient Name: ___________________________________ **Date of Birth:** ___________

The above listed patient authorizes the release of Health Information regarding:

___ 2 years prior from last date seen

___ Date of Service ( ) to ( )

___ Specific Information: ____

___ All Records excluding: __________________________________ **records.**

___ All Records

Facility/Physician: ____

Telephone Number: ___________________ **Fax Number:** ___________________

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: ________________.

If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Patient Signature: ____ Date: ____________________

Mailed/Faxed: _____________

KING OF PRUSSIA MEDICINE

Notice of Privacy Practices for Protected Health Information

<u>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!</u>

With your consent, the practice is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting your symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Example of uses of your health information for treatment purposes:
A nurse obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor determines a need to consult with another specialist in the area. The doctor will share the information with such specialist and obtain input.

Example of use of your health information for payment purposes:
We submit a request for payment to your health insurance company. Your health insurance company requests information from us regarding medical care given. We will provide information to them about you and the care given.

Example of Use of Your Information for Health Care Operations:
We obtain services from our insurers or other business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, and insurance. We will share information about you with such insurers or other business associates as necessary to obtain these services.

<u>Your Health Information Rights</u>
The health record we maintain and billing records are the physical property of the practice. The information in it, however, belongs to you. You have a right to:

- Request a restriction on certain uses and disclosures of your health information by delivering the request in writing to our office. We are not required to grant the request, but we will comply with any request granted;
- Request that you be allowed to inspect and copy your health record and billing record—you may exercise this right by delivering the request in writing to our office;
- Appeal a denial of access to your protected health information except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our office;
- File a statement of disagreement if you amendment is denied, and require that the request for amendment and any denial be attached in all future disclosures of your protected health information;
- Obtain an accounting of disclosures of your health information as required to be maintained by law by delivering a written request to our office. An accounting will <u>not</u> include internal uses of information for treatment, payment, or operations, disclosures made to you or made at your request, or disclosures made to family members or friends in the course of providing care;
- Request that communication of your health information be made by alternative means or at an alternative location by delivering the request in writing to our office; and,
- Revoke authorizations that you made previously to use or disclose information except to the extent information or action has already been taken by delivering a written revocation to our office.

If you want to exercise any of the above rights, please contact Cheryl Perry at 610-265-1251, during normal hours. She will provide you with assistance on the steps to take to exercise your rights.

<u>Our Responsibilities</u>
The practice is required to:

- Maintain the privacy of your health information as required by law;
- Provide you with a notice of our duties and privacy practices as to the information we collect and maintain about you;
- Abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and
- Accommodate your reasonable requests regarding methods to communicate health information with you.

We reserve the right to amend, change, or eliminate provisions in our privacy practices and access practices and to enact new provisions regarding the protected health information we maintain. If our information practices change, we will amend our Notice. You are entitled to receive a revised copy of the Notice by calling and requesting a copy of our "Notice" or by visiting our office and picking up a copy.

<u>To Request Information or File a Complaint</u>

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact Cheryl Perry at 610-265-1251.

Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to Dr. Frederic Becker. You may also file a complaint by mailing it or e-mailing it to the Secretary of Health and Human Services whose street address and E-mail address is:

Secretary of Health and Human Services
The Public Ledger Building
150 S. Independence Mall
Suite #372
Philadelphia, PA 19106-3499
(215) 861-4441

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the practice.
- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

Other Disclosures and Uses

Notification
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.

Communication with Family
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care, if you do not object, or in an emergency.

Food and Drug Administration (FDA)
We may disclose to the FDA your protected health information relating to adverse events with respect to products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers Compensation
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.

Public Health
As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse & Neglect
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.

Correctional Institutions
If you are an inmate of a correctional institution, we may disclose to the institution, or its agents, your protected health information necessary for your health and the health and safety of other individuals.

Law Enforcement
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecutions, or to the extent an individual is in the custody of law enforcement.

Health Oversight
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.

Judicial/Administrative Proceedings
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your consent, or as directed by a proper court order.

Other Uses
Other uses and disclosures besides those identified in this Notice will be made only as otherwise authorized by law or with your written authorization, and you may revoke the authorization as previously provided.

Appointment Reminders
We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters) and/or any necessary pre-operative anesthesia instructions.

Website
If we maintain a website that provides information about our entity, this Notice will be on the website.

I, ____, hereby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I have been given the opportunity to ask any questions I may have regarding this Notice.

____ ________________________

Signature Date

King of Prussia Medicine
860 First Avenue Suite 4B
King of Prussia, PA 19406
Telephone: 610-265-1251
Fax: 610-265-1252

Authorization for Release of Information to Family Members

Patient Name:____ Date of Birth:_____________________

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize King of Prussia Medicine to release my medical and/or billing information to the following individual(s):

1. ____________________________________Relation to Patient: _____________________________

2. ____________________________________Relation to Patient:_____________________________

3. ____________________________________Relation to Patient:_____________________________

Patient Information

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to re-disclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:____Date: _____________________

King of Prussia Medicine

Statement of Patient Financial Responsibility Effective: January 2015

Please sign and date each line.

Patient Name: ______________________________ **DOB:** ______________

King Of Prussia Medicine appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure **payment in full of our fees**. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. **WE EXPECT THESE PAYMENTS AT TIME OF SERVICE**. Many insurance companies have additional stipulations that may affect your coverage. **You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, you will be responsible for your balance in full.**

I have read the above policy regarding my financial responsibility to King Of Prussia Medicine, for providing Medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to King Of Prussia Medicine, the full and entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Additional Financial fees: $30.00 fee for returned checks, patient balances not paid in full after 60 days will incur a $10.00 per month billing charge. Any accounts referred to our Collection Agency will incur an additional $50.00 fee per account.

Patient Signature ______________________________ Date ______________

Guarantor Signature ______________________________ Date ______________
(If guarantor is not the patient)

Self-Pay

I do not have health insurance and will be responsible for services rendered here at King Of Prussia Medicine. I agree to pay King Of Prussia Medicine, the full and entire amount of treatment given to me or to the above named patient at **EACH VISIT.**

Patient/Guarantor Signature ______________________________ Date ______________

Co-Pay- Deductible- Coinsurance Policy:

Some health insurance carriers require the patient to pay **a Co-pay/Deductible/Coinsurance** for services rendered. It is **expected and appreciated at the time the service** is rendered for the patients to pay at **EACH VISIT**. Thank you for your cooperation in this matter.

Patient/Guarantor Signature ______________________________ Date ______________

Cancellation / No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, **we urge you to call 24-hours prior to canceling your appointment. We reserve the right to charge a fee for no show appointments.**

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of four appointments, I may be discharged from care. The Practice will notify you in writing, via certified mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described:

Patient/Guarantor Signature ______________________________ Date ______________

Annual Preventative/Wellness Exam Guidelines:

If you are scheduled for an annual medical exam/ wellness physical, the visit will be submitted to the insurance company as a PREVENTATIVE EXAM. Depending on your insurance policy, an Annual Preventative Wellness Exam may be fully covered by your insurance plan every calendar year from the date of service of the previous year. However, due to various policies offered by individual's insurance plan, some insurance plans may not completely cover this type of exam or cover only a portion of the exam. It is the MEMBER'S RESPONSIBILITY to know their insurance policy benefits and coverage of service.

Preventative Care:

When a service is performed specifically for preventative screening, and there are no known symptoms, illnesses, or history, the service is considered PREVENTATIVE CARE, subject to age and gender guidelines, the health status of the person, and the individual benefit plan.

Diagnostic Care:

Services are considered DIAGNOSTIC CARE when medical treatment for specific health conditions, on- going care, lab or other tests necessary to manage or treat a medical issue or health conditions; (i.e. hypertension, diabetes, orthopedic pain), these services are NOT PREVENTATIVE CARE. Therefore, if during a Preventative Exam, a medical condition is addressed and documented, the visit may be sent to your insurance as an office visit addressing the medical issue in addition to the Preventative Exam. This is a requirement by both the Federal Government and private insurance companies, and may result in a collection of the co-pay or charges against your deductible.

Any tests which may be considered routine (i.e. blood work, EKGs, radiology test, vaccines) may be ordered by the physician, please be aware if your insurance policy covers these services or partially. Any services/tests not covered by your policy may result in YOUR RESPONSIBILITY for the costs.

Finally, all insurance companies require that the physician assign diagnosis codes to each type of service provided, whether it is for a Wellness Exam, Office Visit, or other. Once the physician submits the code for the services rendered to the insurance at the end of the day, the code CANNOT and WILL NOT be altered by the physician or the office staff.

We are required to follow these guidelines in order to comply with current regulations. Therefore, we are informing you of this policy and ask that you sign this form and understand the explanation of services.

Sincerely,

King of Prussia Medicine

____

(Print Patient Name)

____ ________________

(Patient/Guardian Signature) (Date)