

Arthritis and Osteoporosis Associates, PA

Freehold Office Plaza, 4247 Rt. 9 N. Bldg. #1, Freehold, NJ 07728

Tel: (732) 780-7650 • Fax: (732) 780-8817

Deer Chase Professional Park, 150 Route 37 West, Suite A-2, Toms River, NJ 08755

Tel: (732) 341-1166 • Fax: (732) 341-0018

I. 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.

II. WE HAVE A LEGAL DUTY TO SAFEGUARD YOUR PROTECTED HEALTH INFORMATION (PHI).

We are legally required to protect the privacy of your health information. We call this information "protected health information" or "PHI" for short, and it includes information that can be used to identify you that we've created or received about your past, present, or future health condition, the provision of health care to you, or the payment for this healthcare. We must provide you with this notice about our privacy practices that explains how, when, and why we use and disclose your PHI. With some exceptions, we may not use or disclose any more of your PHI than is necessary to accomplish the purpose of the use or disclosure. We are legally required to follow the privacy practices that are described in this notice.

However, we reserve the right to change the terms of this notice and our privacy policies at any time. Any changes will apply to the PHI we already have. Before we make an important change to our policies, we will promptly change this notice and post a new notice in main reception area.

III. HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION.

We use and disclose health information for many different reasons. For some of these uses or disclosures, we need your specific authorization. Below, we describe the different categories of uses and disclosures.

A. Uses and Disclosures Which Do Not Require Your Authorization

We may use and disclose your PHI without your authorization for the following reasons:

1) **For Treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other healthcare personnel who provide you with healthcare services or are involved with your care. For example, if you're being treated for a knee injury, we may disclose your PHI to an x-ray technician in order to coordinate your care.

2) **To Obtain Payment for Treatment.** We may use and disclose your PHI in order to bill and collect payment for the treatment and services provided to you. For example, we may provide portions of your PHI to our billing department and your health plan to get paid for the health care services we provided to you.

3) **For Health Care Operations.** We may disclose your PHI in order to operate this practice. For example, we may use your PHI to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided care to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure you're complying with the laws that affect us.

4) **When a Disclosure is Required by Federal, State, or Local Law, Judicial or Administrative Proceedings, or Law Enforcement.** For example, we make disclosures when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with gunshot or other wounds; or when ordered in a judicial or administrative proceedings.

5) **For Public Health Activities.** For example, we report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, and funeral directors necessary information relating to an individual's death.

6) **For Health Oversight Activities.** For example, we will provide information to assist the government when it conducts an investigation or inspection of a healthcare provider or organization.

7) **For Purpose of Organ Donation.** We may notify organ procurement organizations to assist them in organ, eye, or tissue donation and transplants.

8) **For Research Purposes.** In certain circumstances we may provide PHI in order to conduct medical research.

9) **To Avoid Harm.** In order to avoid a serious threat to the health or safety of a person or the public, we may provide PHI to law enforcement personnel or persons able to prevent or lessen such harm.

10) **For Specific Government Functions.** We may disclose PHI of military personnel and veterans in certain situations. And we may disclose PHI for national security purposes, such as protecting the President of the United States or conducting intelligence operations.

11) **For Workers' Compensation Purposes.** We may provide PHI in order to comply with workers' compensation law.

12) **Appointment Reminders and Health-Related Benefits or Services.** We may use PHI to provide appointment reminders, or give you information about treatment alternatives, or other health care services or benefits we offer.

B. Uses and Disclosures Where You Have the Opportunity to Object:

1) **Disclosures to Family, Friends, or Others.** We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your healthcare, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Authorization.** In any other situation not described above, we will ask for your written authorization before using or disclosing any of your PHI. If you choose to sign an authorization to disclose your PHI, you can later revoke that authorization in writing to stop any future uses and disclosures (to the extent that we haven't taken any action relating on the authorizations).

D. **Incidental Uses and Disclosures.** Incidental uses and disclosures of information may occur. An incidental use or disclosure is a secondary use or disclosure that cannot be reasonably prevented, is limited in nature, and that occurs as a by-product of any otherwise permitted use or disclosure. However, such incidental uses or disclosures are permitted only to the extent that we have applied reasonable safeguards and do not disclose any more of your PHI than is necessary to accomplish the permitted use or disclosure. For example, disclosures about a patient at a nursing station that might be overheard by personnel not involved in the patient's care would be permitted.

IV. WHAT RIGHTS DO YOU HAVE REGARDING YOUR PHI.

You have the following rights with respect to your PHI:

A. **The Right to Request Limits on Uses and Disclosures of Your PHI.** You have the right to ask that we limit how we use and disclose your PHI. We will consider your request but are not legally required to accept it. If we accept your request, we will put any limits in writing and abide by them except in emergency situations. You may not limit the uses and disclosures that we are legally required or allowed to make.

B. **The Right to Choose How We Send PHI to You.** You have the right to ask that we send information to you at an alternate address (for example, sending information to your work address rather than your home address) or by alternate means (for example, e-mail instead of regular mail). We must agree to your request so long as we can easily provide it in the format you requested.

C. **The Right to See and Get Copies of Your PHI.** In most cases you have the right to look at or get copies of your PHI that we have, but you must make the request in writing. If we don't have your PHI but we know who does, we will tell you how to get it. We will respond to you within 30 days after receiving your written request. In certain situations, we may deny your request. If we do so we will tell you in writing, our reasons for the denial and explain your right to have the denial reviewed.

If you request copies of your PHI, we will charge you \$1 per page. Instead of providing the PHI you requested, we may provide you with a summary or explanation of the PHI, as long as you agree to that and the cost in advance.

D. **The Right to Get a List of the Disclosures We Have Made.** You have the right to get a list of instances in which we have disclosed your PHI. The list will not include uses or disclosures that you have already consented to, such as those made for treatment, payment, or health care operations, directly to you, to your family, or in our facility directory. The list also won't include uses and disclosures made for national security purposes, to corrections or law enforcement personnel, or before April 14th.

We will respond within 60 days of receiving your request. The list we give you will include disclosures made in the last six years unless you request shorter time. The list will include the date of disclosure, to whom PHI was disclosed (including their address, if known), a description of the information disclosed, and the reason for the disclosure. We will provide the list to you at no charge, and if needed you can request more copies at no additional charge.

E. **The Right to Correct or Update Your PHI.** If you believe that there is a mistake in your PHI or that a piece of important information is missing, you have the right to request that we correct the existing information or add the missing information. We will respond within 60 days of receiving your written request. You must provide the request and the reason for your request in writing. We may deny your request in writing if your PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, or (iv) not part of our records. Our written denial will state the reasons for the denial and explain your right to file a written statement of disagreement with the denial. If you don't file one, you have a right to request that your request and our denial be attached to all future disclosures of your PHI. If we approve your request, we will make the change to your PHI, to tell you that we have done it, and tell others that need to know about the change.

F. **The Right to Get This Notice by E-mail.** You have a right to get a copy of this notice by e-mail. Even if you have agreed to receive notice via e-mail, you also have the right to request a paper copy of this notice.

V. HOW TO COMPLAIN ABOUT OUR PRIVACY PRACTICES. If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint with the person listed in Section VI below. You also may send a written complaint to the Secretary of the Department of Health and Human Services at 200 Independence Ave., S.W. Room 615F, Washington D.C. 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATION ABOUT THIS NOTICE OR TO COMPLAIN ABOUT OUR PRIVACY PRACTICES. If you have any questions about this notice or any complaints about our privacy practices, or would like to know how to file a complaint with the Secretary of the Department of Health and Human Services, please contact Arthritis and Osteoporosis Associates, P.A., Freehold Office Plaza, 4247 Rt. 9 N. Bldg #1, Freehold, NJ 07728, (732) 780-7650.

VII. EFFECTIVE DATE OF THIS NOTICE. This notice went into effect on April 14, 2003.



Arthritis & Osteoporosis
Associates
Rheumatology At Its Best



Arthritis & Osteoporosis Associates
Rheumatology At Its Best

Registration Form

Last Name _____ First Name _____ Preferred Name _____
D.O.B. ____/____/____ Gender Assigned at Birth: Male Female Gender Identity: _____
Marital Status: S M WID DIV SEP
Address _____ City _____ State _____ Zip Code _____
Home Phone Number: _____ Cell Phone Number: _____
Email: _____

I consent to allow a detailed message from the office to be left at provided phone number(s): **YES NO**

To comply with federal regulations, we are required to ask you to fill out the following:

Race: White ____ Black/African American ____ Asian ____ Asian Indian ____ Other _____

Ethnicity: Hispanic or Latino YES NO

IF YOU DO NOT WISH TO SHARE THIS INFORMATION: _____ Prefer Not to Disclose

I have taken steps to secure a(an): Advanced Directive ____ Living Will ____ Power of Attorney ____
I DO NOT have an Advanced Directive _____

Emergency Contact

Name _____ Phone Number _____ Relationship _____

Primary Care Provider: _____ Phone Number _____

Referring Physician: _____ Phone Number _____

Local Pharmacy: _____ Address _____ City _____
State _____ Phone Number _____

Mail Away (Specialty) Pharmacy _____ Phone Number _____

I hereby grant permission to Arthritis and Osteoporosis Associates to access my full medication history: **YES NO**

I hereby give my consent to Arthritis and Osteoporosis Associates to release PHI (Protected Health Information) about me to the following person(s):

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

I certify that all the information is accurate and acknowledge receipt of the Notice of Privacy Practices. I state that I have read and understand the terms and conditions of the Patient Financial Policy.

Signature _____ Date _____

Arthritis and Osteoporosis Associates
Insurance Information

Is this a Workman's Comp or Motor Vehicle Claim? YES NO

IF YES: Date of Incident ____/____/____ Claim # _____

Adjuster Information

Name _____ Phone Number _____

Email _____ Fax Number _____

Prescription RX Insurance _____ Policy or Member ID _____

Phone Number _____

Primary Insurance _____ Policy or Member ID _____

Group # _____ Name of Subscriber _____ D.O.B. ____/____/____

Relationship _____

Secondary Insurance _____ Policy or Member ID _____

Group # _____ Name of Subscriber _____ D.O.B. ____/____/____

Relationship _____

Tertiary Insurance _____ Policy or Member ID _____

Group # _____ Name of Subscriber _____ D.O.B. ____/____/____

Relationship _____

INSURANCE AUTHORIZATIONS AND ASSIGNMENT, AND PAYMENT RESPONSIBILITY: I hereby authorize Arthritis and Osteoporosis Associates to furnish information to any and all insurance carriers concerning my medical records and treatments. I authorize Arthritis and Osteoporosis Associates to appeal any unpaid insurance claims on my behalf. I hereby assign to the physicians all payments for medical services rendered to myself to my dependents. I acknowledge and understand that I am responsible for all services rendered to me and all the charges incurred from those services. Although I have requested the practitioner to bill my insurance company on my behalf, I clearly understand that I am responsible for any amount not covered by my insurance for any reason. I will also be responsible for my co-pays, co-insurance amounts, and deductibles. Any payments made directly to the patient and owing to the physicians will be remitted immediately, payable to Arthritis and Osteoporosis Associates. Payment is expected when services are rendered. I am responsible for furnishing all the information requested above, and also responsible for furnishing any necessary insurance forms to the office prior to hospitalization or office surgical procedures. IF THERE IS A DEFAULT IN ANY ONE PAYMENT (NO PAYMENT WHEN DUE) THERE WILL BE AN ADDED 25% COLLECTION OR ATTORNEY'S FEE, PLUS ALL COSTS, IF MY ACCOUNT GOES TO A COLLECTION AGENCY OR COLLECTION ATTORNEY FOR COLLECTION OR LITIGATION.

Signature authorizing ALL statements above _____ Date ____/____/____

Print Name: _____ Date of Birth: ____/____/____

Arthritis and Osteoporosis Associates
New Patient Information Form

Patient Name: _____

Appointment Date: ___/___/___

HISTORY

Chief Complaint (Describe Major Symptoms) _____

History of Present Illness (Include: location, severity, timing, associated symptoms, duration) _____

Surgical History _____

MEDICAL HISTORY

Condition	Yes	No	Diagnosis Date	Condition	Yes	No	Diagnosis Date
Cardiac Arrest				High Triglycerides			
Heart Attack				Asthmas/Emphysema			
Diabetes				Thyroid Disease			
Hypertension				Anemia			
Stroke/TIA				Migraines			
CAD(coronary artery disease)				Ulcers			
Heart Murmur				Colitis			
Arthritis/Gout				Hepatitis			
Osteoporosis				Kidney Disease			
Bleeding Tendency				HIV(AIDS)			
Convulsions				High Cholesterol			
Rheumatic Fever				Hereditary Defects			

Heart Rhythm Problem _____ Psychiatric Disorder _____

Cancer (type) _____ Other medical condition _____

Allergic to iodine, latex, shellfish, Tree Nuts/Peanuts, or x-ray dye? YES NO

LIST ANY ALLERGIES/MEDICATION INTOLERANCES IN THE SPACE BELOW:

RHEUMATOLOGICAL	Y/N
Pain Level (1 mild to 10 extreme)	
Tenderness	
Swelling	
Joint Pain	
Fatigue	
Rash	

SOCIAL HISTORY		Never	Rarely	Moderately	Daily
Use of Alcohol	Never				
Use of Tobacco	Never	Previously / Date Quit ___/___/___		Yes	Current Packs/Day_____
Use of Drugs	Never	Yes		IF YES: Type_____	Frequency_____
Caffeine Use	Never	Yes		IF YES: # of Cups per Day_____	

FAMILY MEDICAL HISTORY	Age	IF DECEASED: Cause of Death & Age	Disease/s
Father			
Mother			
Grandmother			
Grandfather			
Sibling			
Sibling			



Arthritis & Osteoporosis
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Rheumatology At Its Best

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Medication Policy

It is important for your health that you follow the directions carefully on all medications that we prescribe. In addition, we must be informed of all other medications, prescriptions, over-the-counter drugs and supplements, that you are taking.

CONTROLLED MEDICATIONS

We will not refill controlled medications in advance of their refill date, **REGARDLESS OF THE SITUATION**, nor will we mail these prescriptions. They must be given in person to you at the time of your appointment. If there is an unavoidable reason that you cannot make an appointment, we require a two-day notice for a medication refill.

Please be advised you will be required to give a urine specimen for drug testing. **Automatic discharge** from the practice will occur for any of the following: forgery or diversion of the prescription, failure to comply with the recommendation of the physician, and any drug seeking behavior including but not limited to using the medication more frequently than recommended, repeated calling after hours to obtain prescriptions, repeated visits to the ER for the pain, use of medication beyond the expected treatment period and failure to notify your physician that you are receiving narcotics from other physicians. You may be referred to a pain management specialist or asked to have an evaluation by a mental health professional to help manage your pain.

STAFF

We require our staff to address our patients with professionalism, and we ask our patients to do the same. **If at any time our staff feels that your tone or language is offensive or abusive**, we expect them to terminate the conversation immediately and notify their immediate supervisor or practice administrator. We will document a record and depending on the severity of the situation, you may be discharged from the practice.

We are committed to providing the best possible treatment and ask for your cooperation in following these policies.

I READ AND UNDERSTAND THE ABOVE POLICIES AND AGREE TO ABIDE BY THEM. I FURTHER UNDERSTAND THAT FAILURE TO DO SO MAY RESULT IN MY DISCHARGE FROM THE PRACTICE.

Signature: _____

(Please sign form in office)

Print Name: _____

Date: _____

Arthritis and Osteoporosis Associates

Patient Financial Policy

Thank you for choosing Arthritis and Osteoporosis Associates as your medical provider. We are committed to building a successful physician-patient relationship. Your clear understanding of our Patient Financial Policy is important to this relationship. Our physicians require that you read and sign the Patient Financial Policy **prior to any treatment.**

Patient Information: It is your responsibility to notify our office of any patient information changes (i.e., Address, Name, Insurance Information, Pharmacy, etc.).

Missed Appointments: If you are unable to keep your scheduled appointment, our office requires a 24-hour notice of your cancellation. Missed appointments that were not previously cancelled may be charged a fee up to \$75.

Insurance Coverage: Insurance policies have become increasingly complex over the years, and it has become impossible for our office to know each specific plan and its limitations. Your insurance policy is a contract between you and your insurance company. Your failure to comply with your insurance company requirements, such as necessary referrals and pre-authorizations, may result in you being responsible for the payment of services. Remember that **YOU** are responsible for knowing your insurance benefits. Please bring your insurance card with you to **EACH** and **EVERY** appointment. In order to properly invoice your insurance company, we require that you disclose **ALL** insurance information, including primary and secondary and inform us of any change in your insurance. Failure to provide complete insurance information may result in you being responsible for the entire bill.

No Insurance/Self-Pay Accounts: Self-Pay accounts are patients without insurance coverage, or patients without an insurance card on file with us. For these patients, payment will be due at the time of service, or prior payment arrangements should be made with our office. Failure to pay the balance in full or failure to enter and remain current on a payment plan may result in your not being seen by a provider in our office. In addition, your account will be forwarded to our legal department for collections procedures.

Out of Network: If our office does not participate with your insurance, payment will be due at the time of service. If your coverage is a plan that we feel may cover office visits, we may elect to take your co-pay/co-insurance at the time of service and invoice your insurance company. You will remain responsible for any amount not covered by insurance. All testing for patients with insurance that our office does not participate with will be scheduled in an outside facility. You may be required to provide credit card information authorizing us to charge for any unpaid services. Our office can provide a list of fees upon request.

Referrals: If your insurance company requires a referral for services, you are responsible for obtaining it. Your failure to do so may result in you being responsible for the entire bill of services.

Co-Pay, Deductibles, & Non-Covered Services: For all insurance plans (including Medicare) that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. This cannot be waived by our practice as it is a requirement placed on you by your insurance carrier. You are responsible for any co-insurance, deductibles, or non-covered services as required by your insurance. You will receive a statement indicating what your insurance has paid, the remaining balance is due upon receipt of the statement. Failure to pay your co-insurance, deductible, or non-covered services, or failure to enter and remain current on a payment plan will result in you not being seen by a provider in our office and you will receive a letter giving you 30 days to choose another Rheumatology group.

Health Share Plans: It is this office's policy to collect full payment for services, unless otherwise specified by your health share plan.

Deductible Health Plans: There are consumer-drive health plans that have a minimum deductible and out-of-pocket limit that is reset each year. If you have a deductible or an out-of-pocket responsibility, Arthritis and Osteoporosis Associates may require you to pay any fee subject to the deductible at the time of your visit. The payment will be applied to whatever patient balance is not paid by your insurance plan, such as, deductibles, co-insurance, co-pays, and/or non-covered services.

Returned Checks: There will be a charge of \$50 for returned checks, which will be payable by cash, credit card, or money order. Returned checks may result in office refusal to accept that form of payment going forward.

Outstanding Balances: It is our office policy that all patient balances be paid in full upon receipt of the patient statement. If full payment cannot be made, payment arrangements can be made by calling our billing department, located in the Freehold office. Failure to pay your balance in full or failure to enter and remain current on a payment plan will result in you not being seen by a provider in our office and dismissed from the practice for financial non-compliance, you will receive a letter giving you 30 days to choose another rheumatology group. If an account is turned over to our collection agency, an additional 25% collection fee will be added to the balance, in addition to all court and legal fees.

KEEP FOR YOUR RECORDS

Arthritis and Osteoporosis Associates
Patient Financial Policy Agreement

I, _____ (Print Name), have received a copy of the Patient Financial Policy from Arthritis and Osteoporosis Associates. I, _____, have read, fully understand, and agree with the expectations set forth.

Signature: _____

Date: _____

DESIGNATION OF DISCLOSURES

You may disclose my health information as described below:

List **ALL** phone numbers we may try to contact you on:

Phone #: _____ home/cell/work (**circle one**)

Phone #: _____ home/cell/work (**circle one**)

Phone #: _____ home/cell/work (**circle one**)

Okay to leave messages: (*Check all that apply*)

On my answering machine

With my spouse

Leave message with call back number only

I designate the following people listed below as persons involved with my healthcare, or payment relating to my healthcare, for the purpose of the practice making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing. **I understand that Arthritis and Osteoporosis Associates will not disclose health information to any person not designated except in the case of an emergency.**

Name: _____ Relation: _____ Phone #: _____

Please list **ALL** physicians you see, in addition to your Primary Care Physician, which may request your records in the future.

Name: _____ Phone #: _____

CHECK HERE TO AUTHORIZE THE RELEASE OF MEDICAL RECORDS TO ANY PHYSICIAN THAT MAY REQUEST IT

Print Name: _____

Signature: _____

Date: _____