One Hudson Medical Associates

New Patient Registration Form

Last Name_____ **Date of Birth**_____/_____/_____

First Name_____ **M.I.**_____

Address:_____

City:_____ **State**_____ **Zip**_____

Home Phone:_____ **Cell Phone:**_____

Work Phone_____ **EXT:**_____

Marital Status: *(Please Circle)* Married Single Other **Sex:** Female Male

Social Security Number:_____-_____-_____

Email Address_____

Ethnicity: *(Optional)* **Please Circle:** American Indian Caucasian Hispanic/Latino
Asian Pacific Islander African American Other

Preferred Language: English_____ Other_____

Pharmacy Currently Used_____ City_____ State_____

Insurance Policy Holders Name *If Different then Yourself*_____

Policy Holders Date of Birth_____/_____/_____

Policy Holders Social Security #_____-_____-_____

Emergency Contact Information: Name_____

Relationship_____ Phone#_____

I authorize any holder of medical information about me to release to the Social Security Administration and the Centers for Medical Services or its intermediaries or carriers or to the billing agent of this physician, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and authorize insurance payments be paid directly to the physician.

Date:_____ **Signature:**_____

HIPAA PRIVACY

Dr. Vishal V. Patel
One Hudson Medical Associates
1829 Hudson Park
Edgewater, N.J. 07020

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that as part of my healthcare, One Hudson Medical Associates (OHMA) originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations.

One Hudson Medical Associates *Notice of Privacy Practices* provides specific information and complete description of how my personal health information (PHI) may be used and disclosed. I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that One Hudson Medical Associates is not required to agree to the restrictions requested. I may revoke this authorization at any time in writing except to the extent that One Hudson Medical Associates has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

Please list family members or other persons, if any, whom may inquire and/or be informed about your general medical concerns/condition/diagnosis:

Name_____**Relationship**_____

Name_____**Relationship**_____

Name_____**Relationship**_____

Signature of Patient/Guardian **Date**_____

_____

_____

Print Patient Name

One Hudson Medical Associates

Patient Financial Agreement

Dear Patient,

This letter sets forth our office financial payment policy:

I understand that as a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement. Full payment is due at the time of delivery of service. I understand that a fee is charged for all visits, examinations, or medical reports. I agree that the determination of the professional services to be rendered by my doctor and the fees to compensate him for these services are matters which concern my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party payer (for example, insurance company, employer, etc.).
The undersigned hereby authorizes the release of any and all information or documents to all parties related to obtaining my insurance benefits for claims submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my physician and all necessary parties to submit claims to obtain benefits, for services 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 if the undersigned had personally signed the particular claim.
I hereby authorize my insurance company to pay and hereby assign directly to One Hudson medical Associates all benefits. I understand I am financially responsible for all charges incurred. I further acknowledge that any insurance benefits, when received by and paid will be credited to my account, in accordance with my insurance company's assignment. Any unpaid charges are my responsibility. Full payment is due at the time of service except if otherwise arranged or mandated by law.
Patient balances are due immediately and are not contingent upon receiving a statement. Insurance companies provide an explanation of benefits outlining payments and patient balances.

There is a $25.00 service charge for a returned check.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW WHAT THE TERMS OF MY INSURANCE ARE, AND IN COMPLIANCE WITH THOSE TERMS, AGREE TO THE FOLLOWING:

1. Providing One Hudson medical Associates with complete and accurate billing information, including, but not limited to, a current insurance card, authorization numbers, and/or referral forms for each visit and/or procedure. I am responsible for all visits and procedures not properly authorized.

2. I will pay all applicable co-pays and outstanding patient balances as they become due. All co-pays and patient balances are due at each visit.

I HAVE READ AND AGREE TO THE TERMS OUTLINED ABOVE

SIGNED (patient or guarantor)_____

Date:_____

FOR (print patient name)_____

One Hudson Medical Associates

MEDICAL APPOINTMENT CANCELLATION POLICY

Dear Patient,

We strive to provide excellent medical care for you, your family, and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets aside ample time for our patients. **"No-shows"** and **late cancellations** inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a MEDICAL APPOINTMENT CANCELLATION POLICY **effective immediately**.

Our Policy is as follows:

1. We request you give our office **24-48 hours** notice in the event you need to reschedule your appointment. Our phone number is 201-941-4111.

2. If we are not contacted within 24-48 hours and your appointment is **MISSED, CANCELLED** or you are a **NO-SHOW, a $25 fee will be assessed and billed to you** and must be paid before or at the time of the next visit.

3. If you are **more than 15 minutes late** for an appointment, we will try to see you as soon as possible once you come but cannot guarantee that you will be seen before another scheduled or waiting patient.

4. Our office makes reminder calls for appointments. If you are registered for the patient portal, you will also receive an email reminder. Please make sure your information is updated at every visit to ensure accuracy when receiving these reminders.

It is ultimately the patient's responsibility to remember their scheduled appointments. This fee will be billed to you directly and is NOT covered by your insurance. This balance must be paid prior to, or at your next appointment. If not paid in a timely fashion this balance is subject to collections.

We that you for trusting your care with One Hudson Medical.

I have read and understand the Medical Appointment Cancellation Policy and agree to the term set forth.

_____

Signature

_____

Date

1829 Hudson Park, Edgewater, NJ 07020 • Phone: 201-941-4111 • Fax: 201-941-4113

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐Yes, I would like to participate in this program.

☐No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -