Internal Medicine Associates of Union, P.C.
Patricia Barsanti, D.O.
PATIENT REGISTRATION FORM

Patient Name:_____ Social Security Number:_____-_____-_____

Date of Birth: _____/ _____/ _____ Sex: M / F Marital Status: (Circle one) Married / Single / Divorced / Widow

Address:_____
(Street) (City/State/Zip)

Home Phone: (_____)_____ Cell Phone (_____)_____

E-Mail Address:_____
Would you be interested in having communications sent to you via your e-mail address? (examples: appointment reminders, administrative updates and health bulletins) *Circle one:* Yes No

Occupation:_____ Employer Name:_____

Employer Address:_____
(Street) (City/State/Zip)

Employer Phone: (_____)_____

How did you hear about our Practice?

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name:_____ Social Security Number:_____-_____-_____

Relationship to Patient (please check): □ self, □ spouse, or □ parent Date of Birth _____/ _____/ _____

Address:_____ Phone Number: (_____)_____

Employer Name:_____ Employer Phone Number: (_____)_____

Employer Address:

_____
(Street) (City/State/Zip)

Who to call for an emergency:

Name:_____ Address:_____

Home Phone: (____) _____-_____ Work phone:(____) _____-_____ Relationship:_____

_____

PRIMARY INSURANCE INFORMATION

Plan Name:_____ I.D. Number:_____

Address:_____ Group Number:_____

Policy Holder:_____ Effective Date: _____

Policy Holder's Social Security Number:_____-_____-_____

Policy Holder's Date of Birth: _____/ _____/ _____ Sex: M / F

SECOND INSURANCE INFORMATION

Plan Name:_____ I.D. Number:_____

Address:_____ Group Number:_____

Policy Holder:_____ Effective Date: _____

Policy Holder's Social Security Number:_____-_____-_____

Policy Holder's Date of Birth: _____/ _____/ _____ Sex: M / F

PHARMACY INFORMATION

Pharmacy Name:_____

Address:_____

Fax Number:_____

Phone Number:_____

IS YOUR VISIT DUE TO A JOB RELATED INJURY OR AUTOMOBILE ACCIDENT? Y_____ N_____
IF YES, PLEASE NOTIFY THE RECEPTIONIST

Patient Signature:_____ Date:_____

Internal Medicine Associates of Union, P.C.
Patricia Barsanti, D.O.

Patient Name:_____
PLEASE PRINT

GOVERNMENT MANDATED QUESTIONS:

RACE: ____White ____Black/African American ____American Indian/Alaskan Native

____Asian ____Native Hawaiian/Other Pacific Islander ____Other ____Decline To Answer

ETHNICITY: ____Spanish/Hispanic Origin ____Not of Hispanic Origin ____Declined/Unknown

In order to comply with federal regulations regarding your privacy, we ask that you complete the following. Do you authorize this office to leave information via:

Home Phone ____YES ____NO Cell Phone ____YES ____NO

Email ____YES ____NO With another person ____YES ____NO (see below)

If you authorize us to discuss information with another person, please provide their information below. Without your written permission, we are UNABLE to discuss any information with anyone.

_____

NAME RELATIONSHIP CONTACT NUMBER

ASSIGNMENT OF BENEFITS:

I irrevocably assign to Internal Medicine Associates of Union, P.C. all my rights and benefits under any insurance contracts for payment for services rendered to me by the providers Internal Medicine Associates of Union, P.C. I am aware that I am responsible for payment of services rendered to me that are not covered by my insurance plan (including if I fail to change my primary care physician to Dr. Barsanti). This assignment of benefits has been explained to my full satisfaction, and I understand its nature and effect.

NAME:_____
Please Print

SIGNATURE:_____ DATE:_____

Dr. Patricia Barsanti, D.O.
154 Mt. Bethel Road. Bldg B
Warren NJ 07059
P: 908-755-5400 F: 908-755-6979

Medical History

Name:_____ Date:_____

1. Please list your current and past medical conditions:

_____ _____

_____ _____

_____ _____

_____ _____

2. Do you have any ALLERGIES to medications, x-ray dyes or other substances? □ Yes □ No
   If yes, please list the name(s) of medication and type of reaction below:

Name of Medication or Substance	Reaction

3. Please list all the medications you are currently taking: *Use back of page if necessary.

Name	Dose	How Often Taken	For How Long

4. Please list and supply dates of any operations:

Type of Operation	Date

5. Please list and supply dates of any Hospitalizations other than surgery:

Type of Hospitalization	Date

6. Family History - Has any member of your family (parents, grandparents, and siblings) ever had the following:

	Which Family Member(s)	Age of Diagnosis
Cancer		
High Blood Pressure		
Diabetes		
Strokes		
Mental Illness		
Bleeding Disorders		
Drug or Alcohol Abuse		
Other Please List		

7. Tobacco Other Please List

Are you a: □ Non-smoker □ Current Smoker □ Past History of Smoking?

□ How much_____ □ Quit Date:_____

Does anyone in your household smoke? □ Yes □ No If yes, Who:_____

8. Alcohol

   Do you drink alcohol? If so, how frequently?: □ Every day □ Socially □ Rare □ Never

9. Recreational Drugs □ Yes □ No If yes, type of drug:_____

10. Prevention

    Do you have a living will? □ Yes □ No Do you have a Donor Card? □ Yes □ No

    Do you have a Durable Power of Attorney for healthcare? □ Yes □ No

11. When was your last:

    Colonoscopy: _____

    Stool checked for blood: _____

    Eye Exam:_____

    Cholesterol check: _____

12. Gynecologic and Obstetric History *<u>*For Females Only*</u>

    Age and Onset of Periods:_____ Frequency: _____ Length of Periods: _____days

    Pregnancies: _____ Births: _____ Miscarriages: _____

    Prolonged or Abnormal Bleeding? □ Yes □ No Please describe:_____

    Leakage of Urine? □ Yes □ No Please describe:_____

    Pelvic Pain? □ Yes □ No Please describe:_____

    History of Abnormal Pap Smear? □ Yes □ No Please describe:_____

    When was your last:

    Pap Smear: _____ Breast Exam: _____ Mammogram:_____

    Bone Density Scan: _____

Internal Medicine Associates of Union, P.C.
Patricia Barsanti, D.O.
Office Policies

In an effort to provide the highest quality care to you, and to ensure an excellent physician-patient relationship, I request that you review the below list of office policies.

1. Please arrive by your scheduled time. In an effort to reduce wait time, any patient more than 20 minutes late for their appointment, may be asked to reschedule to avoid setting back the physician's schedule.
2. Upon arrival, please check-in at the front desk. It is the patient's responsibility to inform the office of any changes to your address, contact information, insurance policy, etc. You must present your current insurance card and driver's license at each visit.
3. The patient is responsible to select Dr. Barsanti as the Primary Care Physician *prior* to the patient appointment. If you do not do so, you will be asked to reschedule your appointment and will not be able to be seen until you select Dr. Barsanti as your Primary Care Physician, as it is required for your appointment.
4. Dr. Barsanti is available to all patients after hours for emergency care (as well as typical "off hours", such as weekends and holidays). In the event that Dr. Barsanti is not "on call", there will be another physician "on call" and available to patients of the practice.
5. Co-payments are collected *upon arrival,* prior to your visit with the physician. Your insurance company mandates that all patients be charged a copay.
6. Also, it is the responsibility of the patient to understand if it is necessary for you to obtain a referral or authorization *prior* to specialists visits or diagnostic testing. We strive to stay current with insurance requirements but the policies change often and without notice, so you are ultimately responsible (although we assist to the fullest extent possible). Please note that many insurance companies require up to 14 business days for Radiology and medication authorizations.
7. If you need a referral, please allow up to 3 business days prior to picking it up in the office. (Many referrals are sent electronically, and may not need to be picked up from the office). If the providers of Internal Medicine Associates of Union, P.C. orders an emergency test, we will provide an emergency referral.
8. In the event that a patient goes to a specialist appointment *without* a referral, Internal Medicine Associates of Union, P.C. is *not* responsible for you needing to reschedule that appointment or any associated fees.
9. If a Specialist orders a study, it is their responsibility to obtain authorization.
10. The billing department can be reached directly at 908-444-4440.
11. Please be advised that Medicare and/or your private health insurance carrier may not cover certain procedures or services that your doctor deems necessary for the complete evaluation and management of your care. This may include various injections, diagnostics tests, etc. Please note that you may be responsible for any balance not paid by your insurance company.
12. Any forms given during/or dropped off after your appointment will typically be ready for pick-up in 3 business days.
13. Any returned checks will be assessed a $50 fee, in addition to any bank fees charged to Internal Medicine Associates of Union, P.C. If a patient provides payment by a check that is returned for insufficient funds more than 1 time, all further payments must be made by cash or credit card.
14. There is a $50 NO SHOW fee for all visits not cancelled with 24 hours or more notice.
15. After 2 NO SHOW's, Internal Medicine Associates of Union, P.C. has the right to dismiss you from the practice.
16. You may request a copy of your medical record. There is a $1.00 charge *per page,* up to a maximum of $100.00 for the copy of your medical record. The processing time for this request is 7 business days.

I have read and agree to the above terms.

_____

Print Name

_____

Signature Date

Internal Medicine Associates of Union, P.C.
Patricia Barsanti, D.O.
Follow Up Pledge

I,_____(print name), hereby acknowledge and understand that even with the best training, skill and experience, a medically trained professional is not always capable of solving my medical problems. Therefore, I understand that it is important that any and all recommendations by doctors are followed completely in order to increase the likelihood of a positive and healthy and treatment/outcome, I acknowledge and understand that if any physician in this office prescribes medicine to me that the proper taking of any such medicine shall be my sole responsibility (or my guardian who has attended this consultation). I agree to properly follow the prescribed dosage and frequently amounts of these medicines as recommended by my doctor.

I understand that if a doctor in this office refers me to see another doctor or receive another test including, but not limited to, a blood test, an MRI, or CT scan, this timely recommendation is important and essential to the ultimate success of my treatment/outcome. I understand that it is not possible for any person in this office to constantly follow-up to ensure that I have followed these recommendations. Therefore, I understand that if I fail to see that specialist or obtain the test for which I was referred immediately, this can risk my current health or increase future health risks.

I understand that it is solely my responsibility to follow any of the medical advice given by any medical person in this office and any bad health outcome from my failure to follow the advice of my doctors should be expected.

I have read and agree to these terms:

_____
Print Name

_____
Signature Date

Internal Medicine Associates of Union, P.C.
Patricia Barsanti, D.O.
Patient Financial Policy Agreement

- I will present proof of insurance coverage at every visit
- I understand it is my responsibility to be educated about the benefits and limitations of my insurance policy.
- I understand my insurance policy is a contract between me and my insurance company. In the event they do not pay for services rendered to me which may include vaccinations, injections and durable medical goods, I am financially responsible for payment for those services.
- If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collections agency, you agree to pay all the collection costs which are incurred.
- I understand that my account may be sent to a professional connection agency if payment is not rendered within 90 days from the billing date and in that event, my relationship with Internal Medicine Associates of Union, P.C. may be terminated.
- I understand that if I disagree with any charges or would like to request an adjustment be made on my invoice or claim, I must contact the billing office in writing within 30 days of the billing date.
- I understand that it is my responsibility to provide Internal Medicine Associates of Union, P.C. with any information necessary to be paid for services rendered to me or anyone covered under my insurance policy or I will be responsible and will pay the balance in full.

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I hereby authorize Internal Medicine Associates of Union, P.C. to apply for benefits on my behalf for covered services rendered by my family physician, or by his/her order. I request that payment form my insurance company be made directly to Internal Medicine Associates of Union, P.C. (or to the party who accepts assignment).

I certify that the information I have reported with regard to my insurance coverage is correct. I agree and accept the terms of the Internal Medicine Associates of Union, P.C. Financial Policy.

I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date:_____

Print Name_____

Signature (Patient/Guardian)_____

HIPAA Form
Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. It is effective April 14, 2003, and applies to all protected health information contained in your health records maintained by us. We have the following duties regarding the maintenance, use and disclosure of your health records:

(1) We are required by law to maintain the privacy of the protected health information in your records and to provide you with this Notice of our legal duties and privacy practices with respect to that information.

(2) We are required to abide by the terms of this Notice currently in effect

(3) We reserve the right to change the terms of this Notice at any time, making the new provisions effective for all health information and records that we have and continue to maintain. All changes in this Notice will be prominently displayed and available at our office.

There are a number of situations in which we may use or disclose to other persons or entities your confidential health information. Certain uses and disclosures will require you to sign an acknowledgement that you received this Notice of Privacy Practices. These include treatment, payment, and health care operations. Any use or disclosure of your protected health information required for anything other than treatment, payment or health care operations required you to sign an Authorization. Certain disclosures that are required by law, or under emergency circumstances, may be made without your Acknowledgement or Authorization. Under any circumstances, we will use or disclose only the minimum amount of information necessary from your medical records to accomplish the intended purpose of the disclosure.

We will attempt in good faith to obtain your signed Acknowledgement that you received this Notice to use and disclose your confidential medical information for the following purposes. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office once you have provided Consent.

Treatment: We will use your health information to make decisions about the provision, coordination or management of your healthcare, including analyzing or diagnosing your condition and determining the appropriate treatment for that condition. It may also be necessary to share your health information with another health care provider whom we need to consult with respect to your care. [If there are other such disclosures that you might make, list them here.] These are only examples of uses and disclosures of medical information for treatment purposes that may or may not be necessary in your case.

Payment: We may need to use or disclose information in your health record to obtain reimbursement from you, from your health-insurance carrier, or from another insurer for our services rendered to you. This may include determinations of eligibility or coverage under the appropriate health plan, pre-certification and pre-authorization of services or review of services for the purpose of reimbursement. This information may also be used for billing, claims management and collection purposes, and related healthcare data processing through our system.

There are certain circumstances under which we may use or disclose your health information **without first obtaining your Acknowledgement or Authorization.** Those circumstances generally involve public health and oversight activities, law-enforcement activities, judicial and administrative proceedings, and in the event of death. Specifically, we may be required to report to certain agencies information concerning certain communicable diseases, sexually transmitted diseases or HIV/AIDS status. We may also be required to report instances of suspected or documented abuse, neglect or domestic violence. We are required to report to appropriate agencies and law-enforcement officials information that you or another person is in immediate threat of danger to health or safety as a result of violent activity. We must also provide health information when ordered by a court of law to do so. We may contact you from time to time to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. [Delete if inapplicable:] You should be aware that we utilize an “open adjusting room” in which several people may be adjusted at the same time and in close proximity. We will try to speak quietly to you in a manner reasonably calculated to avoid disclosing your health information to others; however, complete privacy may not be possible in this setting. If you would prefer to be adjusted in a private room, please let us know and we will do our best to accommodate your wishes.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person’s involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgement. We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death. Finally, we may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your healthcare.

Dr. Patricia Barsanti, D.O
154 Mt Bethel Road. Bldg B
Warren NJ 07059
P: 908-755-5400 F:908-755-6979

Notice of Privacy Practices

Communication Barriers and Emergencies: We may use and disclose your protected health information if we attempt to obtain consent from you but are unable to do so because of substantial communication barriers and we determine, using professional judgment, that you intend to consent to use or disclosure under the circumstances. We may use or disclose your protected health information in an emergency treatment situation. If this happens, we will try to obtain your consent as soon as reasonably practicable after the delivery of treatment. If we are required by law or as a matter of necessity to treat you, and we have attempted to obtain your consent but have been unable to obtain your consent, we may still use or disclose your protected health information to treat you.

Except as indicated above, your health information will not be used or disclosed to any other person or entity without your specific Authorization, which may be revoked at any time. In particular, except to the extent disclosure has been made to government entities required by law to maintain the confidentiality of the information, information will not be further disclosed to any other person or entity with respect to information concerning mental-health treatment, drug and alcohol abuse, HIV/AIDS or sexually transmitted diseases that may be contained in your health records. We likewise will not disclose your health-record information to an employer for purposes of making employment decisions, to a liability insurer or attorney as a result of injuries sustained in an automobile accident, or to educational authorities, without your written authorization.

You have certain rights regarding your health record information, as follows:

(1) You may request that we restrict the uses and disclosures of your health record information for treatment, payment and operations, or restrictions involving your care or payment related to that care. We are not required to agree to the restriction; however, if we agree, we will comply with it, except with regard to emergencies, disclosure of the information to you, or if we are otherwise required by law to make a full disclosure without restriction

(2) You have a right to request receipt of confidential communications of your medical information by an alternative means or at an alternative location. If you require such an accommodation, you may be charged a fee for the accommodation and will be required to specify the alternative address or method of contact and how payment will be handled.

(3) You have the right to inspect, copy and request amendments to your health records. Access to your health records will not include psychotherapy notes contained in them, or information compiled in anticipation of or for use in a civil, criminal or administrative action or proceedings to which your access is restricted by law. We will charge a reasonable fee for providing a copy of your health records, or a summary of those records, at your request, which includes the cost of copying, postage, and preparation or an explanation or summary of the information.

(4) All requests for inspection, copying and/or amending information in your health records, and all requests related to your rights under this Notice, must be made in writing and addressed to the Privacy Officer at our address. We will respond to your request in a timely fashion.

(5) If this notice was initially provided to you electronically, you have the right to obtain a paper copy of this notice and to take one home with you if you wish.

You may file a written complaint to us or to the Secretary of Health and Human Services if you believe that your privacy rights with respect to confidential information in your health records have been violated. All complaints must be in writing and must be addressed to the Privacy Officer (in the case of complaints to us) or to the person designated by the U.S Department of Health and Human Services if we cannot resolve your concerns. You will not be retaliated against for filing such a complaint. More information is available about complaints at the government's web site, http://www.hhs.gov/ocr/hipaa.

All questions concerning this Notice or requests made pursuant to it should be addressed to Internal Medicine Associates of Union, P.C., 10 Shawnee Drive, Suit 3, Watchung, NJ 07069

_____	_____	_____
(Patient's Signature)	(Date)	(Witness)

Internal Medicine Associates, P.C.
Patricia Barsanti, D.O.
154 Mt Bethel Rd
Warren, NJ 07059
Tel. 908-755-5400

"No Call/No Show Policy"

Effective March 30th, 2018, the "No Call/No Show" Policy will be enforced; If a "No Call/No Show" for a scheduled appointment occurs, there will be a $50 fee. No further appointments will be made without payment.

We understand circumstances may arise which make it impossible for you to keep a scheduled appointment. Should this occur, kindly give the office a call to notify us as early as possible, so we may reschedule your appointment.

Our goal is to offer the best possible care to our patients. Notifying us that you cannot keep your appointment will allow another patient to be scheduled during that time.

Thank you for your understanding.

Dr. Patricia Barsanti

By signing below I, _____ (patient name), agree to pay a $50 fee for any appointments that I miss without prior cancellation.

Patient Signature:_____ Date:_____