LIBERTY
MED ASSOCIATES, LLC

PATIENT REGISTRATION

Patient Last Name | Patient First Name | SS #

Street Address | Date of Birth | Marital Status S M W SEP D

City | State | Zip

Tel# Home | Office# | Cell#

Referred by | Email

How did you hear about our office?

Emergency contact | Tel. # | Relationship

PHARMACY INFORMATION

Patient's Pharmacy | Pharmacy Tel#

Pharmacy Address

Online Pharmacy | Account# | Mail Order Address:

PATIENT EMPLOYER INFORMATION

Employer name | Tel. #

Employer street address | City/State | Zip

Patient's Occupation

INSURED PERSON (IF NOT PATIENT)

Name | Tel. # | Date of Birth

Street address | City/State | Zip

Relationship to patient | Employer name

INSURANCE

Medicaid # (if applicable) | Medicare # (if applicable)

Primary insurance co. name

ID# | Group # | Phone #

Secondary insurance co. name

ID# | Group # | Phone #

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFIT

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

Name_____ Signature_____ Date_____

I hereby authorize Dr._____/*Liberty Med Associates, LLC* to apply for benefits on my behalf for covered services rendered by him/her, or by his/her order. I request that payment from my insurance company be made directly to the party who accepts assignment.

I certify that the information I have reported with regard to my insurance coverage is correct.

I permit a copy of this authorization to be used in place of the original. This authorization shall be valid until rescinded in writing or replaced by one of a later date.

Name_____ **Signature**_____

Date_____ *Patient, Parent or Guardian*

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GENERAL MEDICAL INFORMATION

Patient Name:_____ Date of Birth:_____

Present medications:_____
use attached medication log if necessary

Allergies to medication:_____

Allergies (e.g., itchiness or hives) to specific brands of soap/laundry detergent/etc.:_____

Other physicians currently treating you:_____

Previous or other medical problems:_____

List any previous surgeries or hospitalizations (include number of miscarriages and live births):_____

_____

Females only: are you pregnant, planning a pregnancy or nursing a child: ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Cigars/Pipe ☐ Vape No. of yrs._____ How much? _____

Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day?_____

Do you drink coffee? ☐ Yes ☐ No How many cups per day?_____

Are you under a lot of pressure at home or work? ☐ Yes ☐ No

Please describe_____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following?

(Check all that apply)

- ❑ Chest pain/Pressure/Tightening
- ❑ Hypertension
- ❑ Heart attack
- ❑ Stroke
- ❑ Headaches
- ❑ Glaucoma
- ❑ Allergies or Eczema
- ❑ Depression
- ❑ Blood in stool
- ❑ Asthma
- ❑ Dizzy spells
- ❑ Cancer
- ❑ Diabetes
- ❑ Arthritis
- ❑ Difficulty hearing
- ❑ Glaucoma
- ❑ Memory
- ❑ Hemorrhoids
- ❑ Kidney disease
- ❑ Shortness of breath
- ❑ TB/Lung disorder
- ❑ Ulcers
- ❑ Skin disorders
- ❑ Hepatitis
- ❑ Cataracts
- ❑ Digestive problem
- ❑ Frequent urinary infections

Other: _____

IMMUNIZATIONS

(Year last received if known)

Smallpox:_____

Tetanus:_____

Typhoid:_____

Polio:_____

Influenza:_____

Pneumonia:_____

Rubella:_____

Hepatitis:_____

FAMILY HISTORY

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
High blood pressure	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐
Heart attack/Stroke	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐

NOTICE OF PRIVACY PRACTICES

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 health care. 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 disclosure your PHI without your authorization for the following reasons:

1. **For treatment.** We may disclose your PHI to hospitals, physicians, nurses, and other health care personnel who provide you with health care services or are involved in 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 in order to evaluate the quality of health care services that you received or to evaluate the performance of the health care professionals who provided health care services to you. We may also provide your PHI to our accountants, attorneys, consultants, and others in order to make sure we'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 proceeding.

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 health care provider or organization.

7. **For purposes 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 laws.

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. Use and Disclosure 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 health care, unless you object in whole or in part.

C. **All Other Uses and Disclosures Require Your Prior Written 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 relying on the authorization).

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 reasonably be prevented, is limited in nature, and that occurs as a by-product of an otherwise permitted use or disclosure.

However, such incidental uses or disclosure 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 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 requires, 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 to 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, 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 for each 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 to 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 in compliance with National Instant Criminal Background Check System as of 1/7/14.

We will respond within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. The list will include the date of the 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, but if you make more than one request in the same year, we will charge you $10 for each additional request.

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 30 days of receiving your request in writing. You must provide the request and your reason for the request in writing. We may deny your request in writing if the PHI is (i) correct and complete, (ii) not created by us, (iii) not allowed to be disclosed, (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 the 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, tell you that we have done it, and tell others that need to know about the change to your PHI.

F. **The Right to Get This Notice by E-Mail.** You have the 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 that 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, DC 20201. We will take no retaliatory action against you if you file a complaint about our privacy practices.

VI. PERSON TO CONTACT FOR INFORMATIN 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: Liberty Med Associates, LLC, Attn: Human Resources Department; 66 West Gilbert Street, Suite 100; Red Bank, New Jersey 07701-4918; (732) 936-6444; e-mail: info@libertymedmanagement.com.

VII. EFFECTIVE DATE OF THIS NOTICE.

This notice went into effect on January 1, 2015.

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MED ASSOCIATES, LLC

FINANCIAL POLICY STATEMENT

Liberty Med Associates, LLC will send a claim for services rendered to your primary and secondary insurance companies. You may be receiving an explanation of benefits itemizing what was covered and /or paid to *Liberty Med Associates, LLC*.

Liberty Med Associates, LLC will send you a letter/bill asking for any applicable unpaid patient balances. You may also receive an automated reminder call for any balance due. If at any time you feel your insurance company processed your claim incorrectly, please contact them directly.

It is your responsibility to provide accurate insurance information and to obtain coverage information for our services. Please understand that if you fail to make any of the payments for which you are responsible, in a timely manner, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

COPAYS: Your insurance company may require you to pay a share for the doctor's visit. This is due at the time of service.

STATEMENTS and COLLECTIONS: You will be receiving a total of two statements after we reconcile reimbursement from your insurance company. A phone number will be available to call for any billing inquiries. Your account may be sent to collections if no response or payment is received after two statements.

NO SHOW POLICY: It is the policy of this facility to charge a "no show" fee of $25.00 to patients who miss appointments without giving 24 hours' notice.

SELF PAYS: Payment is due at the time of service

MODES OF PAYMENT: We accept cash, check, money orders, VISA and Mastercard.

Every employee on the *Liberty Med Associates, LLC* team is committed to delivering exceptional service to our patients. Thank you for choosing *Liberty Med Associates, LLC*.

By signing below you are stating that you have read and understand this policy:

_____ _____

SIGNATURE DATE

_____

PRINT NAME

OFFICE USE ONLY

Intake Reviewed by: _____ **Date:**_____

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MED ASSOCIATES, LLC

PATIENT AGREEMENTS and CONSENTS

Your privacy is of utmost concern to us at *Liberty Med Associates, LLC* and we strictly adhere to HIPAA regulations. These regulations do allow us to call you at a phone number provided by you for specific purposes. We can call you to remind you of upcoming appointments and to leave either a voice mail message or a message with the person who answers the phone asking you to call us back. We do not leave Personal Health Information (PHI) unless authorized by you.

Please read the following statements and initial to indicate your acknowledgement and/or authorization for each:

_____ I acknowledge that I have received and reviewed a copy of Liberty Med Associates, LLC Notice of Privacy Practices.

_____ I authorize staff of Liberty Med Associates, LLC to leave detailed messages via voice mail on the phone number provided. These messages may contain Personal Health Information (PHI) such as the results of tests.

_____ I authorize the staff of Liberty Med Associates, LLC to leave detailed messages containing PHI with any person answering the following authorized phone number(s):_____ or_____ .
.

_____ *Liberty Med Associates, LLC* collects information including your email address or mobile phone number to deliver patient statements, alerts, and/or e-newsletters. You can opt out of these communications at any time. We will never sell, rent, or give away our email list for 3rd party marketing.

PATIENT PERMISSION TO SHARE PROTECTED HEALTH INFORMATION

_____ I hereby authorize the staff of *Liberty Med Associates, LLC* to use or disclose my health information (referred to as "Protected Health Information") to any healthcare provider and/or employee of *Liberty Med Associates, LLC*. The Protected Health Information (PHI) I am authorizing for use of disclosure is the standard release of information.

_____ I hereby authorize and request *Liberty Med Associates, LLC* to disclose my PHI to the person(s) or institution(s) listed below. I understand I can rescind this authorization at any time and that revocation must be in writing.

Authorized Name(s)	**Relationship to patient**	**Discuss PHI**	
_____	_____	Yes	No
_____	_____	Yes	No
_____	_____	Yes	No

_____ I understand that *Liberty Med Associates, LLC* has the right to bill me $1.00 per page for each copy of my PHI.

By signing this Authorization, I acknowledge that I have read and understand all of the above..

_____ _____
Signature (Patient) Date Signature (Authorized Representative) Date

_____
Name Printed

LIBERTY MED ASSOCIATES, LLC

MEDICATION LOG

Patient Name:_____ DOB:_____

Home Phone:_____ Work/Cell Phone:_____

Pharmacy: _____Pharmacy Number:_____

Date RX	Medication	Dosage	Qty.	Refills	Initials

Notes:_____