

RANDY P. TALAMAYAN, MD BOARD CERTIFIED INTERNAL MEDICINE AND PEDIATRICS JOSEPH C. MORELOS, DO INTERNAL MEDICINE

NOTICE AND PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996(HIPAA), protects health information created or maintained by health care providers throughout the United States.

Prior to receiving care in our office, each patient shall receive and be asked to acknowledge that they have received a Notice of Privacy Practices that explains their rights under HIPAA and our use of their health information for treatment, payment and health care operations without further authorization.

Also as part of the HIPAA regulations, each patient has the right, with some restrictions, to:

- Review his or her own medical record;
- · Request an amendment or correction to the medical record;
- Add supplemental information to the record;
- Restrict use and disclosure of your medical information;
- Authorize formal consent before health information is released other than for treatment, payment or as part of health care operations and
- Know who requested and received medical information for other than treatment, payment, or health care operations

In protection of your information, Jersey Shore Medical and Pediatric Associates, LLC and their employees are prohibited, with some exceptions, from releasing your health information to anyone not involved in your health care or in office operations, including family members, unless you have provided written consent. The Authorization for Release of Information form allows Jersey Shore Medical and Pediatric Associates, LLC to release your information to a particular agency or individual that you designate.

Patient Signature	 Date	

FINANCIAL POLICIES

Thank you for choosing Jersey Shore Medical and Pediatric Associates, LLC. In order to provide your care, we require both treatment and financial compliance. Your clear understanding of our policies is important to our professional relationship.

If your insurance plan requires a **copayment**, it is payable at the time of visit. If you present without the copayment, we reserve the right to reschedule you or to bill you a **\$10.00** administration fee.

If you fail to provide the necessary insurance demographic to file your claim, you will be responsible for payment in full at the time of service. If payment is not received from your insurance company in ninety days, you will be expected to assist in the resolution of the open claim. If the claim continues to be unpaid after 120 days, we reserve the right to bill you directly. It is in your best interest to ensure that the correct insurance information is provided at the time of service.

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A \$1.00 per page for release of medical r	records to a maximum charge of \$100.00
A \$25.00 fee will be charged for missed a	appointments.
If for any reason a payment is dishonored added to your bill and you will be required to pay by for all future services.	d by your bank, there will be a \$25.00 service fee cash, certified check, money order or credit card
We require 72 hours for referrals. priorauthorizations are approved on a case by case by	Please be advised that pre-certifications and basis by your insurance plan.
WE STRONGLY URGE YOU TO FAMILIARIZE YO AND DEDUCTIBLES OF YOUR INSURANCE PLAN	
I hereby certify that I have read Jersey Shore Medic understand my financial responsibility and agree to the	
Patient Name (Print)	
Patient Signature	 Date

DATIENTS MUST INITIAL FOR ACKNOWLEDGEMENT.

PATIENT INFORMATION

Patient's Name						_	
	First		Middle		Last		
Date of Birth			\ge	Sex	☐ Male	Female	
Social Security N	umber			_			
Marital Status	Single	Married	Divorced	<u></u> W	idowed		
E-Mail Address							
Patient's Street A	ddress						
City		_ State		Zip			
Telephone Numb	er		Cel Nun	nber			
Primary Care Doo	ctor Name			Pho	one		
How would you p	refer to be conta	acted?	Phone	Mail			
Medicare requires us to ask the following:							
Race:	Asian	Hispanic	Black	White	e	Declined	
Language:	English	Spanish	Sign Language	e Other		Declined	
Ethnicity:	Latino	Not Latino	Declined				
Employment							
Employer/School	Name						
Occupation							
Years Employed	ull TimePart Time						
Employer's Stree	t Address						
City							
Telephone Numb	er						

Spouse/Parent Information Name D.O.B. Relationship to patient Spouse Pare Othe Street Address _____ City _____ State _____ Zip _____ Telephone Number _____ Nearest relative Relationship to patient? Street Address _____ City _____ State ____ Zip ____ Telephone Number _____ **Motor Vehicle** Is this related to a motor vehicle accident? __Yes Date of accident _____ Claim Number Adjuster's Name _____ Adjuster's Phone Is the claim still open?Yes No Da Closed **Worker's Compensation** Yes Is this a worker's compensation accident? No Date of accident _____ Claim Number Adjuster's Name _____ Adjuster's Phone _____ Is the claim still open?Yes No Da_Closed

Insurance Company Name Street Address ____ City _____ State _____ Zip _____ Policy Type Individual Cobra Group HMO PPO ID Number _____ Group Number _____ Policy Holder's Name ____ First Middle Last Social Security Number - - -D.O.B. _____ Relationship to patient Self Sp 🗀 Par **Secondary Insurance Information** Insurance Company Name _____ Street Address _____ City _____ State ____ Zip ____ Policy Type Individual Cobra Group HMO PPO ID Number Group Number _____ Policy Holder's Name _____ First Middle Last Social Security Number _____ - ____ - ____ D.O.B. _____ Sp Relationship to patient Self Par Patient Name (Print) Patient / Guardian Signature Date

Primary Insurance Information