METROPOLITAN OB/GYN
WOMEN'S HEALTH

1973 Springfield Ave
Maplewood, NJ 07040
P: 973-313-2501 –F: 973-313-2505

HIPAA & REGISTRATION UPDATE FORM

Date: / /	Primary Care Phys. (PCP):	PCP Phone No:

Patients Last Name:	First:	Middle:	Gender: F / M	Marital Status (circle one): Single/Mar/Div/Sep/Widow
Birth Date: / /	Age:	Social Security No: - -	Home Phone No: ( )	Cell Phone No: ( )

Street Address:	City:	State:	Zip Code:

Patient Email:

I authorize messages with medical information to be left on voicemail/answering machine at (check all that apply)
□ Home □ Cell above.
I authorize: □ Brief message details to be left □ Extended message details to be left □ Restrictions:

Local Pharmacy & Phone No:	Address:	City:	State:
Mail-Order Pharmacy & Phone No:	Address:	City:	State:

Please give your insurance card(s) & driver's license to the receptionist.

Name of Primary Insurance Co.:	Subscriber's Name:	Subscriber's SSN: / /	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other – please explain:

Name of Secondary Insurance Co.	Subscriber's Name:	Subscriber's SSN: / /	Subscriber's Date of Birth: / /

Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Partner □ Other – please explain:

Name of Contact:	Relationship to Patient:	Home Phone No.: ( ) -	Cell Phone No: ( ) -

I authorize the following individual(s) to receive information pertaining to any medical history, treatment received and billing matters:

Name:	Relationship to patient:	Birth Date: / /	Contact Phone: □Home□Cell ( ) -

We continue to offer secure electronic communications between you and our office via our Patient Portal. Secure Messages and information can only be read by someone who knows the right password to log in to the Portal site. The Communications are automatically encrypted and for those who want to participate, this secure communication can be a Valuable tool to provide administrative and clinical information provided that we maintain your most up-to-date Information.
Do you wish to either continue to participate or sign up to participate?

□ Yes, I want to participate, my email is:( )□No, I do not want to participate at this time.

I request a female chaperone to be present during my examination. □ Yes □No □Other (family, partner, etc. will be Present).

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize my provider or insurance company to release any information required to process my claims.

Patient Signature: **Date:**

Your Rights:
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in , a civil, criminal or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restrictions to apply.

Your Physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to another Healthcare Physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provide in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

HIPAA Notice of Privacy Practices

Metropolitan OB/GYN, PA.
1973 Springfield Avenue
Maplewood, NJ 07040
(973) 313-2501

THE NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1. Uses and Disclosures of Protected Health Information

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinated, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. It may be necessary to fax your protected health information to another physician, hospital, or agency involved in your care.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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FINANCIAL POLICY

Metropolitan Obstetrics and Gynecology, PA is dedicated to serving patients of all nations with excellence and compassion. By signing this agreement, you are agreeing to follow our company policies.

Please read the following:

Financial Obligations: You are expected to pay your co-pay, deductible, and any out of pocket portions at the time of service by cash, or credit card.

Monthly Statements: if you have a balance on your account, we will send you a monthly statement. Payment is expected on a monthly basis until account is paid in full. If you miss a payment or cannot make a payment then you must contact our billing department at 973-302-8818. Failure to do so may result in a warning letter followed by being turned over to our collection agency.

Annual Exams: This visit includes a pap test, pelvic, and breast exam. This exam also includes the review of current medication prescribed by our office. If you have any additional problems unrelated to your annual exam, an additional office visit will be billed and may result in a co-pay or you may be asked to reschedule your appointment so that your provider will have adequate time to discuss your problems with you. Your health and well-being are important to us.

Charges To Account: We retain the right to cancel your privilege to make charges against your account any time. Future visits would then need to be paid in full at the time of service.

Past Due Account: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. This will also result in dismissal of care from our practice.

Returned Checks: There is a fee of $50.00 to your account for ALL returned checks.

Missed Appointment Fee: Kindly give us 24 hours notice. Failure to do so will result iin a $25.00 fee charges to your account. If you cannot keep an appointment, give us 24 hours notice.

Transferring Of Records: There is a fee of $50.00 for the transfer of your medical records to another facility. Records can be faxed, mailed, or picked up once payment is received. Please allow 72 hours.

Once you have signed this agreement, you agree to all the terms and conditions contained herein and the agreement will be in full force and effect.