NORTH EDISON FAMILY PRACTICE

35-37 PROGRESS STREET, STE- A#3

EDISON, NJ 08820

Last Name: ____________________ **First Name:** __________________ **Middle Name:** _________________

Date of Birth: _____________ **M/F**________ **Social Security Number:** ______________________________

Street Address: ____

City: _________________________ **State:** _____________________ **Zip Code:** ________________________

Home Phone: ________________**Cell Phone:** ________________ **Work Phone:** ________________________

Marital Status: _____________________**Email Address:** ____

Race: Asian, Indian, Hawaiian native, African American, White, Hispanic, Other

Ethnicity: Hispanic, Latin, Non-Hispanic

Language: ____________________________

Emergency Contact Name: __________________________ **Phone Number:** __________________________

Pharmacy Name: ___________________________________ **Phone Number:** ___________________________

Pharmacy Address: ____

Insurance Information

Primary Insurance: _____ Subscriber Name: ______ **Secondary Insurance:** _____ Subscriber Name: ____

Relation: _____DOB: _______ Subscriber ID: _____ Relation: _____DOB: _______ Subscriber ID: ________

Employer Information:

Employer Name: ____

Address: ____ Work Phone: ______________________

AUTHORIZATION TO RELEASE INFORMATION/ASSIGNMENT OF BENEFITS

I hereby authorize North Edison Family Practice (NEFP) to apply for benefits on my behalf for covered services rendered by the practice/physician by physician's orders. I request that payments from my insurance be made directly to NEFP. I authorize to release my medical information necessary to process the claim. I permit a copy of this assignment to be used in place of the original. This information will remain in effect until by me in writing. I am financially responsible for any balance not covered by my insurance company.

Signature: ____ Date: ______________________________

North Edison Family Practice

35-37 Progress Street, Suite A-3

Edison, New Hersey 08820

Phone: 908-755-9797

Fax: 908-668-4845

MEDICATION HISTORY

___ I authorize North Edison Family Practice to access my medication history

___ I do not allow North Edison Family Practice to access my medication history

Patient Name ____

Signature of Patient ________________________ Date: ___________

WEB ACCESS

____ I authorize North Edison Family Practice to send me info through the web.

This allows the North Edison Family Practice to send reminders of appointment and allows patients the ability to look at appointments in past and future.

____ I do not allow North Edison Family Practice to send me info thru the web

E-Mail Address: ____

Print Patient Name: ____

Signature of Patient: ___________________________ Date: __________

INDIVIDUAL PATIENT'S AUTHORIZATION

THIS FORM IS TO CONFIRM YOUR AUTHORIZTION TO USE OR DISCLOSE YOUR PROTECTED INFORMATION FOR A SPECIAL PURPOSE.

1. INDIVIDUAL PATIENT (OR PERSONAL REPRESENTATIVE) CONFIRMING THE AUTHORIZATION

I give my authorization to use or disclose my protected health information as described in section 2 below

I give this authorization voluntarily

Individual Patient's Name: ______________________________ Phone# ____________________

Your address: ____

2. THE USE AND/OR DISCLOSURE AUTHORIZED

Name the people and/or organizations that you are authorizing to use and /or to disclose the protected health information.

____

____

3. ENDING THIS AUTHORIZATION

This authorization will end on the following date:

____

4. CHANGING YOUR MIND ABOUT THIS AUTHORIZATION

I understand that I may revoke this authorization at any time by giving written notice to the Privacy Officer at your office. However, I understand that I may not revoke this authorization for any action taken before receipt of my written notice to revoke this authorization. In addition, I understand that if I am giving this authorization as a condition of obtaining insurance coverage, and I revoke this authorization, the insurance company has a right to contest my claims under the insurance policy.

5. SIGNING THIS AUTHORIZATION IS NOT A CONDITION OF TREATMENT

I understand that under most circumstances a healthcare provider may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization. However, I understand that signing an authorization that permits the use and/or disclosure of my protected health information for research purpose may be a condition of my treatment if I am undergoing research-related treatment. Also, I may be required to sign authorization if my treatment is provided solely for the purpose of creating protected health information for disclosure to a third party. And under some circumstances, a health plan may condition my enrollment in a health plan or my eligibility for benefits on my providing an authorization permitting the health plan to make enrollment and eligibility determinations.

6. INDIVIDUAL PATIENTS'S SIGNATURE

I have had the chance to read and think about the content of this authorization form and I agree with all statements made in this authorization. I understand that by signing this form, I am confirming my authorization for use and/or disclosure of the protected health information described in the form with the people and/or organizations named in this form.

Signature of Patient: ______________________________ **Date:** ______________

North Edison Family Practice Group, LLC

35-37 Progress Street, Suite A3

Edison, N.J. 08820

(T) 908 755 9797

(F) 908 668 4845

Assignment & Release

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to North Edison Family Practice Group, LLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

________________________________ ________________

Responsible Party Signature **Date**

____

Relationship

Bikramjit Singh, M.D.

Nephrology and Hypertension

Internal Medicine

Nabila Gandhi, M.D.

Internal Medicine

NORTH EDISON FAMILY PRACTICE

APPOINTMENT CANCELLATION/NO SHOW POLICY

We understand that situations arise in which you must cancel your appointment. It is therefore requested if you must cancel your appointment you provide more than 24 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

Office appointments which are cancelled or rescheduled with less than 24 hours notification may be subject to a $20.00 cancellation fee.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as NO SHOW. Patients may also be subject to a $20.00 fee for office appointment No Show.

The Cancellation/Rescheduling and No Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment.

We understand that Special unavoidable circumstances may cause you to cancel within 24 hours. Fees in this instance may be waived but only with management approval.
Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Please sign that you have read understand and agree to this Cancellation and No show Policy.

________________________________ **Date of birth** __________
Patient Name (Please Print)

________________________________ __________
Signature of Patient or Patient Representative Date

NORTH EDISON FAMILY PRACTICE

Follow Up Agreement

I understand that it is my responsibility to call North Edison Family Practice within a week to follow up on results after going for any radiology imaging, blood work and/or any other tests, IF I have NOT heard back from the office regarding my test results.

When a Follow up Appointment Is Necessary

There are four main reasons a doctor will order a test:

- To diagnose a condition
- To measure how effective a treatment is
- To track the progression of a chronic illness
- To check for the recurrence of a treated condition

The results of the test may be simple and straightforward—say, positive or negative—or be more nuanced or open to interpretation. Even if the news is "good," it may be important for the doctor to explain what the results mean and don't mean. This is especially true if you are undergoing diagnosis for a suspected condition or follow-up for a treated one.

Remember that getting the results of a test may also prompt new questions, which you can use this appointment to ask.

Please be advised that it is the patient's responsibility to follow up after any test done.

Do not assume that the results are normal just because you have not heard back from our office.

_______________________________ _______________

Patient Signature **Date**

NORTH EDISON FAMILY PRACTICE, LLC
35-37 Progress St # A3, Edison, NJ – 08820
Phone : 908-755-9797 Fax : 908-668-4845

TELEMEDICINE SERVICES CONSENT FORM

Patient's Name: ______________________________ DOB: ____________________

Informed Consent for Telemedicine Services

- I understand that telemedicine is the use of electronic information and communication technologies by a healthcare provider used to deliver services to an individual when he/she is located at a different location or site than I am.
- I understand that the telemedicine visit will be done through two-way video link-up. The healthcare provider will be able to see my image on the screen and hear my voice. I will be able to hear and the healthcare provider.
- I understand that the laws that protect privacy and the confidentiality of medical information including (HIPAA) also apply to telemedicine.
- I understand that I will be responsible for any copayments or coinsurances that apply to my telemedicine visit.
- I understand that I have the right to withhold or withdraw my consent to use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
- In understand that by signing this form that I am consenting to receive healthcare services via telemedicine.

Signature of Patient: ______________________________ Date: ____________________

Patient's Phone: ________________________

Email: ____

Witness: ____