COMPLETE PRIMARY CARE, P.A.

RABIN ROZEHZADEH, M.D.

1810 Park Avenue
South Plainfield, NJ 07080
Office (908) 226-1810 Fax (908) 226-1833

PRIVACY POLICY

OUR "NOTICE OF PRIVACY PRACTICES" PROVIDES INFORMATION ABOUT HOW WE USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU. THE NOTICE CONTAINS A PATIENTS RIGHT SECTION DESCRIBING YOU RIGHTS UNDER THE LAW. YOU HAVE THE RIGHT TO REVIEW OUR NOTICE BEFORE SIGNING THIS CONSENT. THE TERMS OF OUR NOTICE MAY CHANGE. IF WE CHANGE OUR NOTICE, YOU MAY OBTAIN A REVISED COPY BY CONTACTING OUR OFFICE.

YOU HAVE THE RIGHT TO REQUEST THAT WE RESTRICT HOW PROTECTED HEALTH INFORMATION ABOUT YOU IS USED OR DISCLOSED FOR TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. WE ARE NOT REQUIRED TO AGREE TO THIS RESTRICTION, BUT IF WE DO, WE SHALL HONOR THAT AGREEMENT.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFGORMATION ABOUT YOU FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS. YOU HAVE THE RIGHT TO REVOKE THIS CONSENT, IN WRITING SIGNED BY YOU. HOWEVER, SUCH REVOCATION SHALL NOT AFFECT ANY DISCLOSURES WE HAVE ALREADY MADE IN RELIANCE ON YOUR PRIOR CONSENT. THE PRACTICE PROVIDES THIS FORM TO COMPLY WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA).

CONSENT TO RELEASE INFORMATION

BY SIGNING THIS FORM I PERMIT THE PRACTICE TO RELEASE ANY MEDICAL INFORMATION TO THE PHYSICIANS INVOLVED IN MY CARE. I CONSENT THAT THE PRACTICE MAY CALL MY HOUSE OR OTHER DESIGNATED LOCATION AND LEAVE MESSAGE ON VOICEMAIL OR IN PERSON IN REFERENCE TO APPOINTMENTS, REMINDERS AND PATIENT STATEMENTS. IN ADDITION, THE PRACTICE MAY MAIL TO MY HOME APPOINTMENT REMINDER AND PATIENT STATEMENTS.

I DESIGNATE THE FOLLOWING REPRESENTATIVE WHO THE PROVIDER CAN COMMUNICATRE WITH ON MY BEHALF. IF YOU DO NOT DESIGNATE ANYONE, THE DOCTOR WILL BE UNABLE TO SPEAK TO ANYONE IN MY FAMILY REGARDING MY MEDICAL CONDITION.

NAME RELATIONSHIP

NO SHOW POLICY- $50.00 FEE

YOU WILL BE CONSIDERED A NO-SHOW IF YOU MISS AN APPOINTMENT AND DO NOT NOTIFY US AT LEAST 24 HOURS IN ADVANCE. COMPLETE PRIMARY CARE, PA WILL MAKE EVERY EFFORT TO REMIND YOU OF YOUR APPOINTMENT, PLEASE UPDATE YOUR HOME, WORK AND CELL NUMBERS EACH TIME YOU VISIT THE OFFICE.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

SIGNATURE ON FILE

I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF TO COMPLETE PRIMARY CARE, PA AND OR ITS PROVIDERS FOR THE SERVIE FURNISHED TO ME. I AUTHORIZED ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO BE RELEASE TO HIGHMARK MEDICARE SERVICES AND ANY OTHER MEDICAL CARRIERS, ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR SERVICES. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF ORIGINAL.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

PRINT PATIENT'S NAME OR LEGAL GAUDIAN DATE