RABIN ROZEHZADEH, MD
1810 PARK AVE
SO. PLAINFIELD NJ 07080
(908)226-1810 FAX: (908)226-1833

PATIENT INFORMATION

Name:____________________ Email:____________________

SSN:__________

Home Phone:______________ Cell Phone:______________

Address:____________________

City:______________ State:________ ZIP:________

Sex ☐ M ☐ F Age:______ DOB:__________

Marital Status:

☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Occupation:______________ Phone:______________

Business Address:____________________

In case of Emergency, who should we notify?____________________

Do you have: an Advanced Medical Directive or Living will? ☐ Y ☐ N

How did you hear about us? ______________ How do you plan to pay?__________

INSURANCE

Responsible Party:____________________

Relation to Patient:______________ DOB:________ SSN:________

Address:____________________ Phone:__________

City:______________ State:______ ZIP:______

Insurance Company:____________________

Subscriber No.:______________ Group No.:______________

ADDITIONAL INFORMATION

Race:

☐ White ☐ Hispanic ☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian/Pacific Islander

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Decline

Preferred Language: ____________________

ASSIGNMENT AND RELEASE

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

Signed:____________________ Date:__________

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 INFORMATION 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 REMINDERS AND PATIENT STATEMENTS.

I DESIGNATE THE FOLLOWING REPRESENTATIVE WHO THE PROVIDER CAN COMMUNICATE 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:__________________________

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 SERVICE 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 GUARDIAN DATE

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

Appointments

1) We value the time we have set aside to see and treat you. We would appreciate 24-hour notice of any cancellation or change in appointment. **There will be a charge of $50.00 as a No Show Fee for all missed appointments with no prior notification.**
2) **If a patient has multiple missed appointments we reserve the right to remove that patient from our panel and that patient will not be granted any appointments in the future.**
3) We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4) Complete Primary Care, PA will make every effort to remind you of your appointment, please update your home, work and/or cell phone numbers each time you visit the office.

Initial: __________

Insurance Plans

Please understand

1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
2) If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.
3) It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example
   a. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.
4) It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: __________

Referrals

1) Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
2) It is your responsibility to know if a selected specialist participates in your plan.
3) Remember, referrals are based on the Doctor's request for expert advice from a specialist, therefore all referrals must be requested by or approved by your Family Physician.
4) Most referrals are paper documents; you must pick these up in hand prior to your appointment. Please respect other patients' needs, we cannot start filling out a new referral and faxing it the day of your appointment because you lost it or forgot to pick it up.

Initial: ___________

Financial Responsibility

1) According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
2) **Co-payments** are due at the time of service.
3) Self-pay patients are expected to pay for services in **<u>FULL</u>** at the time of the visit.
4) If previous arrangements have *not* been made with our finance office, any account balance outstanding longer than 90 days will be forwarded to a collection agency and incur in a 45% collection fee.
5) Patients forwarded to collection will no longer be accepted back into our practice, unless payment is made in full.
6) For scheduled appointments, prior balances must be paid prior to the visit.
7) If you participate with a high-deductible health plan, we require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
8) We accept cash, checks, money orders, and all mayor credit and debit cards.
9) A $45 fee will be charged for any checks returned for insufficient funds.

Initial: ___________

Transfer of Records

1) If you transfer to another physician, we request at least 48 hours' notice.
2) While we will gladly send you to a specialist for a second opinion, however we promote the idea of a "medical home" Therefore, if you transfer due to dissatisfaction with our office staff or physicians and have received care elsewhere, we will not accept your family back into our practice.
3) We provide records for visits (including consultations from specialists) rendered here at Complete Primary Care only. For any previous records, you must request them directly from your previous doctor(s).

Initial: ____________

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)____

Responsible Party Member's Signature ____________________________________ **Date** _________________________

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

Signed:____ **Date**: ____________________________ tial

Print Name:____