Comprehensive Endocrinology PC
Ari Geliebter MD • Rebecca F Geliebter MD

240 West Passaic Street, Suite #14, Maywood NJ 07607
Telephone: (201) 903-0070 Fax: (201) 322-0287

■ Patient Information

Name (Last, First, Middle) _____ Today's Date _____

Date of Birth _____ **Soc. Sec. #** _____ **Home Phone** _____

Email address _____ Work Phone _____

Address _____ **Apt #** _____ Cell Phone _____

City _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F

Marital Status: Single Married Partnered Divorced Widowed Separated **Work Status:** F/T Work P/T Work Retired Disability

Who may we thank for referring you? _____

Primary Care Physician _____ Phone _____

■ Guarantor's Information

Only to be used by patients with a legal guardian. If the patient has no guardian, please skip this section.

Name (Last, First, Middle) _____ **Home Phone** _____

Date of Birth _____ **Soc. Sec. #** _____ Work Phone _____

Address _____ **Apt #** _____ Cell Phone _____

City _____ **State** _____ **Zip** _____ **Sex:** ☐ M ☐ F

Employer's Name _____

Employer's Address _____

■ Primary Insurance

Insurance Carrier & ID Number _____

Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____ **Sex:** ☐ M ☐ F

Relationship to Patient _____ Soc. Sec. # _____ **Date of Birth** _____

■ Secondary Insurance

Please complete section if applicable. If there is no secondary insurance, please skip this section.

Insurance Carrier & ID Number _____

Please give the receptionist your card, to scan into our files. If the patient is the policyholder, check this box ☐ and skip to the next section.

Policyholder's Name (Last, First, Middle) _____ **Sex:** ☐ M ☐ F

Relationship to Patient _____ Soc. Sec. # _____ **Date of Birth** _____

■ Assignment and Release

I hereby authorize payment directly to Comprehensive Endocrinology, PC of all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered to and for me. If my insurance plan requires an authorization or referral, and I do not obtain one for the services I receive, I understand that I am responsible for all charges, even if the provisions of my plan stipulate I otherwise wouldn't be. I authorize the doctors and/or any provider or supplier of services in this office to release all information required to secure the payment of benefits, including protected health information. I authorize the use of my signature on all insurance submissions. I authorize a copy of this document to be used in place of the original. I have read and agreed to the above.

Signature: _____ Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

■ Pharmacy

Preferred Pharmacy Name _____ Phone _____

Address _____

■ Medical History Questions

Please list dosage of all **medications**, including over the counter medications and supplements:

_____

_____

_____

Please list all **allergies**:

_____

_____

For women only: Last menstrual period:_____ Number of pregnancies: _____

Do you currently smoke or chew **tobacco**? Yes No

If Yes, how much per day? _____ If No, did you smoke in the past? Yes No

Do you currently drink **alcohol**? Yes No

If Yes, how many drinks per day? _____ If No, did you drink in the past? Yes No

Do you currently use **illegal drugs**? Yes No If Yes, which ones? _____

■ Chief Complaint

What symptom(s) or condition(s) are the **reason you are here today**?

_____

_____

_____

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FINANCIAL POLICIES

Upon scheduling and registration we require you to provide your medical insurance card (if you are utilizing its coverage, it must be brought to every visit), photo identification, your address, date of birth, and phone number. If you receive health benefits through a spouse, partner or parent, we require you to provide that person's full address, date of birth, and phone number. For collection purposes, we require social security numbers as well. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the appropriate authorities.

Keeping Appointments: Should you not arrive for a scheduled office visit, unless that appointment has been cancelled at least 1 full business day in advance, you may be charged $50 for each no-show occurrence. Should you no-show twice within a 12 month period, you may be dismissed from the practice. Arriving more than twenty (20) minutes late for an appointment without calling ahead shall be considered a no-show occurrence.

Medicare: If you have coverage with Medicare (including both original Medicare and commercial Medicare Advantage plans), it is your responsibility to understand the provisions of your health insurance plan and coverage. Every original Medicare beneficiary is responsible for an annual deductible and a coinsurance. Medicare Advantage beneficiaries may be responsible for an annual deductible, coinsurance and/or a copayment. Any portion of copayment, coinsurance and deductible which is not covered by a supplemental carrier will be your financial responsibility to pay. You are wholly responsible for your coverage limitation, regardless of whether you are aware of the details. If you have both Medicare coverage and also commercial insurance, you are responsible for providing the correct primary insurance at your visit. If you have supplemental insurance that does not cross over automatically, you will be billed for the deductible and coinsurance, and you may be given a receipt to submit yourself. By signing below you specifically agree to these terms, and exempt yourself from any protections your insurance plan may offer you regarding these provisions.

Commercial Health Insurance Plans: Although we will advise you whether we believe we participate with your insurance carrier, we are not responsible for any verbal assurances made to you regarding whether particular services rendered in this practice are covered by your plan. You and you alone are responsible for understanding the provisions of your health insurance plan and coverage. We recommend contacting your carrier prior to receiving services in order to verify your financial responsibilities.

Tertiary Insurance: If you have more than two insurance policies in effect, we will submit claims only to the primary and secondary insurance. You will be invoiced for any remaining balance, and you may be given a receipt to submit yourself to a tertiary plan.

Referrals: You are responsible to obtain all necessary referrals prior to your appointment, if required by your health plan. We will do our best to ensure you have one if you need one, but the ultimate responsibility is yours. If your plan requires a referral or authorization that you do not obtain, and your health plan refuses to pay for any claim for lack of a referral or authorization, you explicitly agree to be responsible for our charges for any affected visits, even if the provisions of your plan stipulate you otherwise wouldn't be (you are waiving that defense). If you come to an appointment without a required referral, your appointment will be rescheduled for another day.

Copayments: If your plan has a copayment, if is your responsibility to pay it at the time of service, even if the amount it not printed on your insurance card. Please have your payment ready upon check-in. Please be aware that, should you not pay your copayment at the time of service, you will be responsible to pay a fee of $25.

Direct Patient Payment: If your insurance plan issues payment to you instead of to us, you are responsible to turn the entire payment over to us immediately upon receipt together with the complete explanation of benefits form. You may be responsible for an additional balance, depending on how your insurance plan adjudicates such a claim.

Unpaid Balances: It is our policy to invoice patients for balances due in the mail and, when possible, electronically. However, if you do not pay your invoices in a timely fashion, your account may be sent to collections. In that event,

you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations.

Bounced Checks: If you pay with a personal check, and that check fails to clear the bank for any reason (known as a bounced check), you will incur a $35 fee, and may not be able to pay by personal check in the future. We do not attempt to re-deposit bounced checks. When a check bounces, that balance plus fee is immediately due, and may be paid via credit card, cash, cashier's check or money order only.

Health Insurance Non-Payment: Services that have not been paid by your health insurance carrier within 60 days of claim submission will become your financial responsibility to pay in full. In cases of retroactive disenrollment, you shall be responsible for all charges immediately upon notification to us by the carrier.

Self-Pay Patients: If you do not have health insurance, or are receiving a service known to not usually be covered, it is our policy that you must pay for your services before leaving the office. If you have insurance through an out-of-network insurance to which we do not agree to submit claims on your behalf, you must ask for a complete receipt at the time of service which you can use to submit for potential reimbursement.

Financial Assistance: Healthcare can be expensive. If you find yourself in a difficult financial situation, and would like to ask us for a payment plan, please do so immediately upon receipt of the first invoice.

Laboratory Testing: If you are a member of an insurance plan that requires you to have your laboratory specimens sent to a particular laboratory, and this office is so informed by you, we will happily send your specimens to that laboratory, unless the provider determines that another laboratory is preferred for medical reasons. However, regardless of which laboratory patient specimens are sent to for analysis, you are entirely responsible for all charges assessed by the laboratory, and shall handle financial matters directly with the laboratory.

Financial Security and Collections: It is our policy to request patients to keep a credit card on file as financial security against deductibles, co-insurance and other instances of patient balances due to us as outlined in this document. You shall continue to be sent invoices in the mail. However, if you do not pay your invoices in a timely fashion, we reserve the right to add a 10% penalty for failure to pay your invoices, and charge the credit card on file for the new total amount as a stop-gap to avoid sending accounts to collections. However, if you do not pay your invoices in a timely manner, and you do not provide a credit card for our files, or the card you provide is not valid or funded when we attempt to use it, your account shall be sent to collections. In that event, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. You may be dismissed as a patient by our practice for failure to meet your financial obligations. Please give the receptionist your credit card to record and store in our secure password-protected credit card system.

Credit Card Charges: If you pay for your charges with a credit card and feel the charges are either unwarranted or otherwise nor your responsibility based on the provisions of your health insurance plan, you must first contact our billing department before contacting your credit card vendor. If you contest credit card charges without first contacting us, or you contest credit card charges which your insurance carrier has applied to your financial responsibility, and those charges are reversed by the credit card vendor or merchant bank, your balance due may be immediately treated as overdue debt, a collections fee may be appended, and the entire account may be sent to our collection agency, as outlined above, in the Financial Security and Collections paragraph.

I have read, fully understand, accept and explicitly agree with all the above policies at and of Comprehensive Endocrinology, PC. I fully understand and accept my financial responsibility for the charges I or my dependents may incur at this office. My signature also acts as authorization to use the credit card provided in this document as explained above in the Financial Security and Collections paragraph.

Patient Name (Please print clearly): _____

Signature: _____ Date: _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

♦ Comprehensive Endocrinology, PC and its staff and providers, may use and disclose my Protected Health Information* ("PHI") to carry out treatment, payment and healthcare operations (TPO). I understand and acknowledge that Comprehensive Endocrinology, PC's Notice of Privacy Practices has a more complete description of such uses and disclosures.

♦ I have received your Notice of Privacy Practices and/or I have been provided an opportunity to review it. I understand and acknowledge that Comprehensive Endocrinology, PC reserves the right to revise its Notice of Privacy Practices at any time, and that a revised version of that notice may be obtained sending a written request to the Privacy Officer at the practice.

♦ I permit Comprehensive Endocrinology, PC to leave telephone messages regarding my appointments, prescription renewals, lab results, and all other PHI, may be left for me on voicemail systems and answering machines, or given the person or persons who answer the phone, at the following telephone numbers, in addition to any other numbers provided to you by me:

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

(__ __ __) __ __ __ - __ __ __ __ Home / Office / Cell / Other: _____

[If we need to contact you with lab results, please place a check mark next to the preferred contact number, if any.]

♦ I agree that my PHI may be shared with my spouse.

♦ I agree that my PHI may be shared with my other medical providers.

♦ I agree that my PHI may be shared with the following other people:

_____ _____

_____ _____

♦ I understand that I can change or revoke any of the foregoing agreements, at any time, by giving written notice to Comprehensive Endocrinology, PC to the attention of the HIPAA Compliance Officer. I understand and acknowledge that Comprehensive Endocrinology, PC may decline to provide me with any services should I decline to sign this agreement, or should I later revoke this agreement.

♦ I agree that my PHI may be shared with my credit card vendor(s) if I contest any credit card charges, so that Comprehensive Endocrinology, PC can submit records to support its charges.

♦ I agree that Comprehensive Endocrinology, PC may contact me at any email addresses provided to you by me regarding both PHI and non-PHI.

**as defined in the Health Insurance Portability and Accountability Act of 1996 and its regulations, as may be amended from time-to-time ("HIPAA")*

Patient Name (Please print clearly): _____

Signature: _____ Date: _____