PREMIER FAMILY MEDICINE

Authorization for Verbal Release of Protected Health Information

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

Telephone Numbers where we can leave messages:

Home: _____ Work: _____ Cell: _____

Mail Results to Home Address on File **YES:**_____ **NO:**_____

I_____ _____ **Give My Permission To:**

PREMIER FAMILY MEDICINE

to release information regarding appointment dates / times and my protected health information, including but not limited to, insurance, address, phone numbers, test results, financial information, health care information, and treatment to the following:

Name of Person: _____ Relationship to Patient: _____

Exceptions: _____

I Understand That:

- I may revoke this Authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this Authorization. Unless revoked, the automatic expiration date will be 12 months from the date of the signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of this Authorization.
- Information authorized for verbal release may include protected health information related to mental health.
- The information authorized for verbal release may include drug / alcohol abuse treatment records. This category of medical information / records is protected by Federal confidentiality rules (42 CFR Part 2) The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CRF Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

Signature: _____ Date: _____

PREMIER FAMILY MEDICINE
5 WALTER FORAN BLVD, SUITE 4000
FLEMINGTON, NJ 08822
908-824-7179

Thank you for choosing Premier Family Medicine for your medical needs. We are committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient Financial Responsibilities

The patient (or patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.

We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance, phone numbers, and address at the time of the office visit. If we do not receive correct insurance information the patient will be responsible for any unpaid balance on their visits.

Copays are due at time of visit. If we need to bill you then a $5.00 surcharge will be added to your bill unless other arrangements have been made.

If you have an outstanding balance you will be billed as well as given a bill at the next office visit for which that balance will be paid at that time unless other arrangements are made.

Hospital Assistance patients will be charged 50% of their bill due at the time of service. Vaccines will be paid at full price.

There is a $40.00 extra charge for returned checks.

HMO insurance plans- should our doctor not be listed as the primary doctor the patient/guardian will be responsible for the office visit.

If we have not received payment in a timely manner you will receive a delinquent notice. If we have not received payment within 60 days of initial visit then all outstanding balances will be turned over the a collection agency.

I hereby authorize assignment of financial benefits directly to Premier Family Medicine and any entities for services rendered as allowable under standard third party contracts. I understant that I am financially responsible for charges not covered by this assignment.

Patient Name_____

Patient Signature_____
Date: _____

As part of the new government requirements, we are required to obtain additional Demographic information including the data listed below.

Thank You!

Patient Name:_____ DOB: ____/____/____

(Please circle your responses)

RACE

Declined to Answer
American Indian or Alaska Native
Asian
Black or African American
Multiracial
Native Hawaiian or other Pacific Islander
Other Race
Unknown
White

PREFERRED LANGUAGE

Declined to Answer
Albania
Arabic
Bulgarian
Cambodian
Central Khmer
Chinese
English
French
German
Haitian; Haitian Creole
Hebrew
Hindi
Italian
Japanese
Korean
Other
Filipino
Polish
Portuguese
Russian
Somali
Spanish
Spanish; Castilian
Thai
Urdu
Vietnamese

ETHNICITY

Declined to Answer
Hispanic or Latino
Not Hispanic or Latino
Unknown/Not Reported