FOR 25 YRS & OLDER

( ) REFUSED

Hunterdon Healthcare
Your full circle of care.

2100 Wescott Drive, Flemington, NJ 08822 • 908-788-6100
www.hunterdonhealthcare.org

DURABLE POWER OF ATTORNEY FOR HEALTH CARE (PROXY DIRECTIVE)

NAME DOB

If you wish, you may use this section to designate someone to make treatment decisions if you are unable to do so. Your Living Will declaration will be in effect even if you have not designated a proxy.

I, _____ , designate the following person as my health care representative to make any and all health care decisions for me, acting in my best interest, in the event that I become incapable of making decisions for myself.

Name _____ Relationship _____

Street _____

City _____ State _____ Zip _____ Telephone _____

If the person I have named above is unable to act as my health care representative, I hereby designate the following person(s) to do so:

1. Name _____ Relationship _____

   Street _____

   City _____ State _____ Zip _____ Telephone _____

2. Name _____ Relationship _____

   Street _____

   City _____ State _____ Zip _____ Telephone _____

SPECIFIC DIRECTIONS: Please initial the statement below that best expresses your wishes.

_____ My health care representative is authorized to direct that artificially provided fluids and nutrition, such as by feeding tube or IV infusion, be withheld or withdrawn.

_____ My health care representative does not have this authority, and I direct that artificially provided fluids and nutrition be provided to preserve my life, to the extent medically appropriate.

Signed _____ **Date** _____

Witness (cannot be health care representative or alternative representative listed above).
I declare that the person who signed this document or asked another to sign this document on his/her behalf, did so in my presence and that he/she appears to be of sound mind and free of duress or undue influence.

Witness _____ **Date** _____

Witness _____ **Date** _____

Reminder: Give a copy of this document to your doctor, health care representative, and other concerned individuals.

Written and approved by the Medical Society of New Jersey 7/95.

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Permission to Share Protected Health Information with Family, Friend, or Caregiver

(Use *Authorization for Disclosure of Protected Health Information* form to share information with other healthcare providers or insurance companies)

Patient's Full Name:_____ DOB:_____

This authorization is given by: _____ Patient for self _____ Parent/Guardian

If the patient is a minor, this form gives consent to share with someone other than the parents.

☐ ***I DO NOT*** wish to list anyone.

The physicians/practice may disclose protected health information to:

(examples- spouse, parents, children, caregiver, friend)

First & Last Name	Relationship	Phone Number

I understand that the Physician/Practice may disclose protected health information including the entire medical record. Specific exceptions, if any, are noted here: _____(Initials)

_____

I understand that the purpose of the use/disclosure is for continued medical care. _____(Initials)

I understand this authorization is in force until it is revoked in writing, and I may revoke authorization at any time in writing. _____(Initials)

A detailed message may be left on patient's voicemail/answering machine ☐ YES ☐ NO

Note: message will be left ONLY if recorded greeting identifies you by name

Preferred confirmation method: ☐ CALL ☐ TEXT

Printed name of patient/guardian Signature Date

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

Jonathan E. Wierzbicki, MD
Daniel Carducci, PA
Peggie Perkin, NP

FINANCIAL POLICY

Premier Family Medicine realizes that you have a choice in medical providers and are pleased that you have chosen us to care for you and your family. We believe that part of a good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you and or your family and want you to completely understand our financial policy.

PAYMENT

It is a policy of our office that your co-payment be collected at the time of service. Any outstanding balance after insurance has paid will be billed to you. If there is still a balance on your account our office will hand you a bill at the next office visit at which time you will be required to pay off then unless other arrangements have been made with our billing manager.

There will be a $40.00 extra charge for returned checks for insufficient funds.

Cancellations need 24 hours notice or you will be charged $25 No Show.

Deductibles, co-insurance, and copayments are part of your contractual agreement with your insurance company. In the event that your balance is not paid in full within 60 days of your first statement you will receive a delinquent notice. After that if it still is not paid you will receive a letter requesting payment with a payment plan. Balances over $500 will require a minimum payment of $100.00 per month, $50 monthly payment on any balances under $500.00. If your account is outstanding 6 months or greater it will be transferred to a collection agency.

MEDICAL INSURANCE

Our office will need a copy of all your insurance cards as well as a photo ID.

We participate with most insurance plans including Medicare. Please inquire with our office or your insurance carrier for our participation with your insurance. Payment will be due at the time of service if we do not participate with your insurance. Medical insurance Coverage is an arrangement between the insurance carrier and you, the patient. Understand that it is your responsibility to know your insurance coverage and you are financially responsible for the services provided by our office. We accept cash, Checks, Discover, Visa, and MasterCard for your convenience.

HUNTERDON MEDICAL CENTER PATIENT ASSISTANCE PROGRAM (CHARITY CARE)

Our office does not participate with HMCPAP but we will discount the office visit to half of the original charge to be paid at time of visit. IF HMCPAP is secondary to Medicare, patients are required to pay their Medicare deductible in full. Balances left after all insurances have paid will be paid at 50% of that balance.

SURGICAL PROCEDURES

In the event that your surgical procedure is not covered by your insurance, payment for these procedures will be your responsibility.

MEDICAL RECORDS

A copy of your medical records created at Premier Family Medicine will be released only with your written consent. After completing the appropriate Records Release Authorization Form please allow 7-10 business days to process this request. Our office requires a records retrieval fee of $1.00 per page not to exceed $100.00. Before copies are released all fees and accounts must be paid in full.

FORMS

The completion of forms, (school, working papers, temporary disability, disability, FMLA, etc.) requires both office staff and physician time; therefore there will be a $15.00 form fee to be paid at the time you drop off the form.

SELF PAY FINANCIAL POLICY

All cash patients and patients that present without valid insurance information are considered a SELF PAY Patient. All Self-Pay patients are required to pay at the time the service in the office is rendered. We accept Master Card, Visa, Discover, and checks.

Premier Family Medicine has permission to contact me regarding my account at:

Home Phone:_____at these convenient times:_____.

Mobile Phone:_____at thise convenient times:_____.

Work Phone:_____at these convenient times:_____.

All copayments, co-insurances, deductibles, and outstanding balances must be settled before seeing our physicians. Our office reserves the right to immediately cancel your care for conduct, non-cooperation or non-payment.

Your signature represents your acknowledgement of full financial responsibility and your understanding and acceptance of the policies of our office's financial contract detailed above.

_____ _____

Print Name of Patient or Responsible Party Patient Date of Birth

_____ _____

Signature of Patient or Responsible Party Date