MEDICAL ART CENTER | PATIENT REGISTRATION

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenterni.com

Name	Last		First		MI
Street					
City		State		Zip	
Home Phone		Email			
Cell Phone		Birthdate	/ /	Age	
Gender	☐ Male ☐ Female	Employer			
Race		Work Phone			
Soc Sec #		☐ Full Time	☐ Part Time	☐ Retired	
Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Pharmacy				Phone	
Emergency Contact				Phone	
Referred By: Check All That Apply	☐ Friend	☐ Family	☐ Patient		
	☐ Facebook	☐ Doctor		☐ Healthgrades	
	☐ Billboard	☐ TV	☐ Work	☐ Instagram	

PRIMARY INSURANCE INFORMATION **For claim processing, please provide your insurance card(s) to the receptionist*

Insurance Company				
Insured Individual Last		First		MI
Address (if different)				
Birthdate		Soc Sec#		
Relation to Patient	☐ Self	☐ Spouse	☐ Child	☐ Other
Employer		☐ Full Time	☐ Part Time	☐ Retired
		Work Phone		

SECONDARY INSURANCE INFORMATION

Insurance Company				
Insured Individual Last		First		MI
Address (if different)				
Birthdate		Soc Sec#		
Relation to Patient	☐ Self	☐ Spouse	☐ Child	☐ Other

I hereby assign the policy rights and benefits to the Doctor, and authorize direct payment for professional services rendered. I further authorize the attending Doctor to release any information concerning my examination or treatment to my insurance company. I agree to be personally responsible for any unpaid balance, deductible or co-payment to the Doctor; and if I perceive any payments from my insurance company in error, I will sign them directly over to the Doctor.

Signature of Patient, Parent, Guardian or Personal Representative

DATE

Name		Date	/ /
Patient Concerns			
Date of Last Physical			

CONFIDENTIAL FAMILY MEDICAL HISTORY

	Alive	Age of Death	Present Health or Cause of Death		Alive	Age of Death	Present Health or Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
			Age of Living Children				

CHECK (✓) THE ILLNESSES THAT HAVE OCCURRED IN YOUR IMMEDIATE FAMILY

__Diabetes	__Cancer	__Bleeding Tendency	__Kidney Disease	__Tuberculosis
__Heart Disease	__Stroke	__High Blood Pressure	__Depression	__Allergies

MEDICATIONS and dosage you are currently taking, INCLUDE vitamins, herbs, supplements, etc.

CHECK (✓) IF YOU ARE ALLERGIC TO

__Adhesive Tape	__Ibuprofen	__Latex	__Aspirin
__Iodine	__Penicillin	__Local Anesthesia	__Sulfa

List any Allergies to medications or substances:

Do you take oral contraceptives? __No __Yes	Please list any of the following:

CHRONIC CONDITIONS	ACCIDENTS	DIAGNOSTIC TESTS
INJURIES/ILLNESSES	HOSPITILIZATIONS	SURGERIES

OTHER HEALTH CARE PROVIDERS

Primary Care	OB/GYN
Preferred Pharmacy	

Name **Location** **Number**

Living Will | Advance Directive? __No __Yes	May we have a copy for your chart? __No __Yes

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I or my minor child every have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative **DATE**

Please PRINT name of Patient, Parent, Guardian or Personal Representative

HIPAA Notice of Privacy Practices

Medical Art Center | 950 State Route 35 | Middletown NJ 07748 | 732-888-0017

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

This Notice of Privacy Practices is NOT an authorization. This Notice of Privacy Practices describes how we, our Business Associates and their subcontractors, may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

-You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
-We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

-You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
-We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

-You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
-We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

-You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
-If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

-You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
-We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

-If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
-We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

-You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

Complaints You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Compliance Officer of your complaint. **We will not retaliate against you for filing a complaint.**

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.In these cases, you have both the right and choice to tell us to:

-Share information with your family, close friends, or others involved in your care
-Share information in a disaster relief situation
-Include your information in a hospital directory *[If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

In these cases we never share your information unless you give us written permission:

-Marketing purposes -Sale of your information -Most sharing of psychotherapy notes

In the case of fundraising:

-We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.
Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.
Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.
Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as:

-Preventing disease - Helping with product recalls - Reporting adverse reactions to medications - Reporting suspected abuse, neglect, or domestic violence - Preventing or reducing a serious threat to anyone's health or safety

Do research
We can use or share your information for health research.
Comply with the law
We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests
We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director
We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
We can use or share health information about you:

- -For workers' compensation claims
- -For law enforcement purposes or with a law enforcement official
- -With health oversight agencies for activities authorized by law
- -For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
We can share health information about you in response to a court or administrative order, or in response to a subpoena.
Our Responsibilities

- -We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind
- -We are required by law to maintain the privacy and security of your protected health information.
- -We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- -We must follow the duties and privacy practices described in this notice and give you a copy of it.
- -We will never share any substance abuse treatment records without your written permission.

Changes to the Terms of this Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Receipt of the Notice of Privacy Practices

Name of Patient or Representative **Date**

PATIENT CONFIDENTIALITY (HIPAA)					
Name			**Date of Birth**		
Patient confidentiality is one of our priorities and it is the law (HIPPAA) implemented in 2003. Your privacy is a great concern in our office. Please indicate below with whom and where we may leave a message. When possible we try to confirm appointment as well as leave messages regarding medication, test results, and billing information.					
OUR OFFICE MAY LEAVE A MESSAGE AT					
HOME |Yes| No		**CELL |Yes| No**		**WORK |Yes| No**	
Due to our confidentiality requirements, should a family member, friend, or relative contact our office, please state who we have permission to discuss your condition/results with					
Name		**Relation**			
Name		**Relation**			
Name		**Relation**			
***Please provide your email address to receive office information and initial_____ to acknowledge consent of test results and bloodwork via email:**					
Please be advised that it is your responsibility to inform us if any changes should be made to the above information. Thank you.					

MEDICAL ART CENTER | CANCELLATION POLICY

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Dear Patient,

If you need to cancel a FOLLOW UP appointment, we REQUIRE a notice of 24 hours or a **$50.00 fee** will be charged.

If you need to cancel a PHYSICAL appointment, we REQUIRE a notice of 72 hours or a **$75.00 fee** will be charged.

If you miss your appointment WITHOUT notifying the office, there will be a **$75.00 fee**.

Special testing such as ECHO'S, ULTRASOUNDS AND NERVE STUDIES REQUIRE a notice of 72 hours or there will be a **$50.00 fee**. If you miss your appointment for these procedures without notifying the office, the charge will be **$100.00 fee**.

By signing this cancellation policy, you are AWARE of the fees associated with cancelling your appointment. You must notify the office according to the policy above.
Failure to do so will result in a fee.

Patient Name _____

Patient Signature _____ **Date** _____

Witness _____ **Date** _____

MEDICAL ART CENTER | NETWORK & BILLING
950 State Route 35 Middletown, NJ 07748 732 -888-0017 www.medicalartcenternj.com

PATIENT DISCLOSURE OF NETWORK AND BILLING INFORMATION

Welcome of the Medical Art Center, LLC. We consider it a privilege to be selected as your health care provider. The following disclosure is made to inform you of billing matters pertaining to your care at this facility.

Please take notice that some physicians or diagnostic facilities, including but not limited to laboratory services, who are associated with this facility may not be participating providers with your insurance carrier. If the physician of facility is not a participating provider with your insurance carrier, then part or all of the medical services that you receive from the respective physician or facility will be considered "out-of-network". Services provided by out-of-network provides or facilities will be reimbursed by your insurance carrier at the out-of-network benefits level. This could mean that you may have additional out-of-network expenses not covered by your insurance carrier for which you will be personally responsible. Please do note that the information provided herein is for the out-of-network disclosure purpose only and is not a representation of insurance plan coverage.

The Medical Art Center, LLC is available at 732-888-0017 to discuss questions about your insurance plan coverage and related financial responsibility.

You have the right to make informed decisions about your care including the right to make decisions concerning accepting, refusing or choosing from alternatives or medical and/or surgical treatments. You also have the right to utilize physicians or facilities not affiliated with Medical Art Center, LLC. A list of geographically convenient alternative physicians or facilities is available upon request. The physicians, nurses and the entire staff at Medical Art Center, LLC are committed to your care.

I, the undersigned, do hereby acknowledge and agree to the foregoing Billing Disclosures provisions.

_____

Patient Name **Date of Birth**

_____

Please PRINT name of Patient, Parent, Guardian or Personal Representative **Date**

_____

Relationship to Patient

_____

Witness **Date**

MEDICAL ART CENTER | FINANCIAL POLICY
950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

PATIENT FINANCIAL POLICY

Thank you for choosing our office as your healthcare provider. We are committed to making your treatment successful. You are required to read and sign the following office financial policy prior to the commencement of any treatment.

Your insurance plan is an agreement between you and your insurance carrier. We are not party to that contract. You are responsible to know you policy. If your insurance plan requires a referral prior to the commencement of treatment, it is your responsibility to have one prior to the commencement of examination or treatment.

You hereby authorize insurance payment directly to our office. Should payment be sent to you, it is your responsibility to return the check to our office, within ten (10) days of receipt. Failure to do so will result in civil collection proceedings for the amount of the check(s) wherein you agree to pay all the interest, reasonable attorney, collection agency fees and costs incurred in collections. You further assign your rights to benefits under your contract of insurance of other third party payment to Medical Art Center, LLC and Shamra Medical Laboratory and its employees, agents and/or contractors, all benefits payable to you under your insurance policies and health benefits plans.

You hereby further provide Medical Art Center|Shamra Medical Laboratory with a limited irrevocable power of attorney to endorse any checks or other negotiable instruments made payable to you individually or jointly to you, Medical Art Center|Shamra Medical Laboratory. This power expressly authorizes third parties including but not limited to commercial banking institutions to honor our endorsements on your behalf under this power of attorney and to accept deposit or cashing of any such negotiable instrument. This limited power of attorney shall be immediately effective and shall be durable in that it shall remain in full effect through any disability of the principal granting this power of attorney.

You hereby authorize Medical Art Center|Shamra Medical Laboratory to pursue any means necessary to collect all charges on your account as assignee and/or you Designated Authorized Representative including follow up calls, appeals, arbitration, and civil suit, if allowable by law.

THIS FINANCIAL AGREEMENT IS A VALID CONTRACT BETWEEN THE PATIENT AND THE HEALTH CARE PROVIDER. I CERTIFY THAT I HAVE READ THE ABOVE IFORMATION, OR THAT THE INFORMATION AS PATIENT UNDER THIS AGREEMENT.

_____

Patient Signature

_____

Please PRINT name of Patient, Parent, Guardian or Personal Representative

_____

Date

_____

Witness **Date**

MEDICAL ART CENTER | PATIENT DUTIES & AGREEMENT

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Name_____ Date_____

I have sought the clinical and health care services of the Medical Art Center, LLC, for my personal healthcare or for my child(ren) who are minors. As a condition to treating at the Center, I agree as follows:

_____initial Our office and its employees make no representations, claims or guarantees regarding the efficacy of our recommendations. The protocols we recommend are based upon a combination of our clinical experience and knowledge of scientific and medical literature. With this information individualized protocols may be offered and applied as either adjunctive or primary protocols for certain conditions.

_____initial You may be prescribed and or referred for diagnostic and/or consultations with healthcare providers or facilities not affiliated with the Medical Art Center, LLC. You agree and acknowledge that it is your responsibility as a patient to attend these referrals as well as follow up with the service provider concerning the results of such testing and/or consultations or other services. Medical Art Center, LLC, cannot do this for you and by signing this form you agree to assume this responsibility as a condition to treating at the Medical Art Center, LLC. It should not be assumed on the part of the patient that if they are not contacted by the Medical Art Center, LLC or its employees, or if the patient does not schedule or keep consultation, that test results are normal (or without abnormalities), and may not require further follow ups or advice. Health/medical recommendations and/or possible referral and additional follow up may be warranted based upon laboratory testing and evaluations. Patient hereby agrees to follow up directly with the third party provider of consultations and/or testing directly.

_____initial Patient acknowledges and agrees that the Medical Art Center, LLC and/or Ammar Bazerbashi, MD may refer or order testing but not perform interpretation of such testing, which is done by other licensed healthcare providers. Thus, patient acknowledges and agrees that the Medical Art Center, LLC and/or Ammar Bazerbashi, MD are not responsible for any such interpretations of testing and agrees to hold them harmless in this regard.

_____initial In consideration for the services performed for the patient by Medical Art Center, LLC patient agrees to indemnity and hold harmless the Medical Art Center, LLC, its members, employees, agents and contractors from any and all liability arising from other healthcare providers that utilize the testing, records, or other information from patients' treatment and cause harm or damages to the patient.

_____initial By signing this Agreement, you agree to hold harmless the Medical Art Center, LLC, its owners, employees, and contractors from all professional and personal liability, negligence, or other legal liability arising from you duties and agreements as a patient herein. You agree to be responsible for all legal costs and fees that may result from actions(s) on your part or on the part of your representative(s) against us. You have the right to have this agreement reviewed by your lawyer before accepting any services from our office and we suggest that you exercise this right.

_____initial By signing this Agreement, patient also expressly agrees not to audio tape, video tape or otherwise record in any media any encounter with the staff or doctors at the Medical Art Center, LLC or at any time while on the premises of the Medical Art Center, LLC.

Name_____ Date_____

Witness_____ Date_____

DISCLOSURE OF INSURANCE PARTICIPATION STATUS

The laws of the State of New Jersey and New Jersey Department of Health and New Jersey Department of Banking & Insurance require that a health care professional inform patients of the health care plans in which the professional participates in and the facilities with which the professional is affiliated with. In compliance with these laws, the undersigned patient is hereby notified, in writing, that:

Dr. Bazerbashi/Nurse Practitioner is **Out of Network** with Cigna, Aetna, United Healthcare, Horizon and ALL Blue Cross Blue Shield

The following testing will be interpreted by **OUT OF NETWORK DOCTORS:**

***EKG, Spirometry, Stress ABI, Segmental ABI, Nerve Studies, Holter Monitors, Take Home Sleep Studies, Attended Sleep Studies, Ultrasounds, Echos, Vein Ultrasounds, CPETs.**

Any CPAP supplies are **OUT OF NETWORK.**

The following services offered at Medical Art Center are **OUT OF NETWORK** with Horizon:

***Chiropractor, Acupuncture, Pain Management**

BLOOD WORK, SWABS, AND OTHER TESTING PERFORMED AT OUR OFFICE WILL BE SENT TO **OUT OF NETWORK** LABORATORIES.

The patient is hereby notified and understands that these services may not participate with the patient's health insurance plan and may be "out of network providers" subject to the following disclosures. Patient may contact their health plan or administrator for further consultation on costs associated with these services.

Mandatory Disclosures:

Patient Initials : _____ I understand that Medical Art Center has health care professionals that are "out of network" with and does not participate with my health insurance plan.

Patient Initials : _____ I understand that the amount or estimated amount the health care professional will bill me or the covered person for the services is available upon request:

Patient Initials: _____ I understand that I may request from the provider an estimated charge for the services proposed and the Current Procedural Terminology (CPT) codes associated with that service, and the health care professional shall disclose to me, the patient, in writing, the amount or estimated amount that the health care professional will bill the covered person for the service.

Patient Initials : _____ I understand that I will have a financial responsibility applicable to health care services provided by an out of network professional, in excess of my in network copayment, deductible, or coinsurance, and that I may be responsible for any costs in excess of those allowed by my health benefits plan.

Patient Initials : _____ I have been advised that I should contact my health insurance plan or administrator for further consultation on those costs:

Acknowledgment of Receipt of Disclosures- OUT OF NETWORK PATIENTS

I, the undersigned patient, acknowledge receipt of this disclosure form from my health care provider, and have read it and understand the contents. I have discussed my option to obtain treatment with other health care providers, service providers, or at alternate health care facilities that may participate with my health plan and I waive the right to do so and wish to obtain treatment at this office with full notice of these disclosures and potential cost sharing consequences. I certify that I am at least 18 years of age, competent, not under the influence of any drug, alcohol, or other substance that would impair my ability to understand these disclosures, am not being coerced to sign this disclosure, and do upon my own free will.

Signature: _____

Print Name: _____

Date: _____

MEDICAL ART CENTER | Diagnostic Studies/Procedures

950 State Route 35 Middletown, NJ 07748 732-888-0017 www.medicalartcenternj.com

Patient Name: _____

Medical Art Center is proud to be a comprehensive and all-embracing facility that promotes healing and wellness across the board. We go out of our way to offer our patients an extensive array of services and diagnostic studies/procedures for early diagnosis, prevention, and treatment of various ailments from mild to severe.

It is extremely challenging to house all of these procedures under one roof. However, we have been successful in providing our patients this courtesy and convenience. If any of our providers/doctors orders a diagnostic procedure, and if your insurance permits, we will schedule it in our office.

*_____ **If your insurance requirement is that the diagnostic studies/procedures be done at a specific facility, or <u>IF YOU CHOOSE to have the diagnostic studies/procedures performed out of our office</u>**, we will **GLADLY** provide you a script to **<u>the facility of your choice</u>**, as well as the prior authorization information, if needed.

Keep in mind that undergoing these diagnostic studies/procedures will extend the duration of your visit.
Medical Art Center thrives on providing the Ultimate in Medical and Wellness Care for a Healthier Future. We will continue to strive to practice evidence-based medicine. We guarantee your satisfaction, and we are always open to any questions, suggestions, or criticism. Thank you being a part of our practice.

Signed: _____

Dated: _____