Adult & Pediatric
UROLOGY of HUNTERDON

5 Walter Foran Boulevard, Suite 4001
Flemington, NJ 08822
Phone: 908-751-5939
Fax: 908-751-5938

Patient Information

Name (Last, First, Middle) | SSN# | Birth Date | Language | Sex | Street Address | City | State | Zip Code | Home Phone | Work Phone | Cell Phone | Email Address | Ethnicity | Race | Primary Care Physician | Referring Physician | Pharmacy Name | City | State | Do we have your permission to confirm your appointment? | If Yes, at which number do you permit us to contact you at to confirm?

Responsible Party Information (If different than above)

Name (Last, First, Middle) | SSN# | Birth Date | Language | Sex | Street Address | City | State | Zip Code | Home Phone | Work Phone | Cell Phone | Email | Relationship to Patient

Primary Insurance

Name of Insurance Company | Policy # | Group # | Name of Insured | Date of Birth | Relationship to Patient

Secondary Insurance (if applicable)

Name of Insurance Company | Policy # | Group # | Name of Insured | Date of Birth | Relationship to Patient

Emergency Contact

In Case of Emergency, please contact | Relationship to Patient | Home Phone | Work Phone | Cell Phone

Name (Last, First, Middle) _____ Birth Date _____

Do you have a Living Will or Advanced Directive? _____ If No, would you like more information on one? _____

HOW DID YOU HEAR ABOUT OUR PRACTICE? (please check one)

- ☐ My Primary Physician
- ☐ My Specialty Physician (i.e. Gastro, Endo, OB/GYN)
- ☐ My Insurance Company
- ☐ Internet Search
- ☐ Other _____

ACKNOWLEDGE RECEIPT

I acknowledge receipt of Patient Bill of Rights. _____ INITIAL

I acknowledge receipt of Notice of Privacy Practices. _____ INITIAL

AUTHORIZATION FOR DISCLOSURE OF PHI

I hereby authorize Adult & Pediatric Urology of Hunterdon to verbally disclose my medical information, including but not limited to: lab test results, imaging test results, billing/claim/insurance information, making and confirming appointments with the following individuals:

1. _____ Relationship to Patient _____
2. _____ Relationship to Patient _____
3. _____ Relationship to Patient _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at Adult & Pediatric Urology of Hunterdon to 5 Walter Foran Blvd, Suite 4001 Flemington, NJ 08822. I understand that a revocation is not effective to the extent that action has already been taken prior to date of notification.

I understand that certain information cannot be released without specific authorization as required by state and federal law. By initialing the lines below I authorize the release of the following protected or sensitive information to the above named individuals:

INITIALS

- ☐ Information regarding diagnosis and treatment for HIV/AIDS and other communicable disease
- ☐ Information regarding mental health/behavioral health/pyschiatric care
- ☐ Information regarding alcohol and/or drug use and/or treatment

SIGNATURE X _____ Date: _____

OR

I **DO NOT** authorize Adult & Pediatric Urology of Hunterdon to release any or all information concerning my medical care to any individual except in the event of a critical episode or if I am unable to give my authorization due to the severity of my medical condition.

SIGNATURE X _____ Date: _____

Assignment / Release / Consent to Treat

Permission is hereby granted to healthcare providers within this practice to administer such testing, examinations, treatment and procedures as are deemed necessary in the course of my care. Information about me necessary to substantiate my insurance claims may be released by the healthcare provider involved in my care. I authorize payment directly to the provider's office of all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all charges whether or not paid by my insurance, for all services rendered on my behalf or on my dependents behalf.

Signature of Patient/Parent/Guardian: X _____ Date: _____

Save Form

NOTE: Please do not e-mail the form to us. Only use this functionality to save your information on your computer, if you cannot fill the whole form all in one session.

Print Form

Print a copy of this form and bring it in with you.

HIPAA Privacy Policies

Patient Bill of Rights

Health Information Sharing and Electronic Medical Records